INVENTORY OF BASIC SERVICES TO CHILDREN IN INDIA

UNITED NATIONS CHILDREN'S FUND (UNICEF)

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Inventory of Basic Services to Children in India

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INTRODUCTION

The Inventory of Basic Services to Children in India was first compiled in October 1976. Though it was preliminary and incomplete listing, it was felt to be useful both within the UNICEF and outside. Hence it was updated in 1978; and is being further updated in 1981. Even so, it is still incomplete; in fact, any such inventory in a country like India will always remain incomplete.

While certain organizations which figured in the 1978 Inventory have had to be deleted from the current one due to lack of up-to-date material/information on them (many do not respond to queries asked or individual letters sent out); certain others have undergone a change in priorities, etc; hence there may be slight discrepancies in this volume as compared to the earlier one.

The Inventory has been organized with a view to ease of reference and updating. The 31 States/Union Territories in India have been allotted, following their alphabetical order, 100 serial numbers each. The number along with the major focus of the project, and the name of the State are given at the right hand corner of the first page of each project. The twelve items of each project follow a uniform numbering system for easy reference. They occur in the order shown below:

1. Started
2. Coverage
3. Activities
4. Personnel and Training
5. Supervision and Records
6. Community and Other Participation
7. Sponsorship and Funds
8. Evaluation
9. Problems
10. Outlook
11. Contact
12. Reference

We hope to follow up on gaps in the information later.

Satish Prabasi
Regional Planning Officer

CONTENTS

No. 1
Health and C.C
Andhra Pradesh

Andhra Mahila Sabha, University Road, Hyderabad

1. Started In 1938.

2. Coverage: General Centres in the whole state of Andhra Pradesh.

3. Activities:

a. Educational Services:

Balwadis with Primary Schools attached, high schools, arts and science colleges, functional literacy programmes for farmers in eight districts in Andhra Pradesh. This is integrated with child-care and family welfare programmes.

b. Health:

Hospitals, Family Planning Clinics, ANM training.

c. Rehabilitation Centres:

Orthopaedic centres for the treatment, education and rehabilitation of the physically handicapped children.

d. Training and Employment Services:

Handicrafts training institute - in printing and dyeing textiles, toy-making, leather-work, packaging and binding.

6. Community and Other Participation:

a. Government Representatives participate in committee meetings as members or invitees.

b. The Sabha works closely with the State and Central Governments.

10. Outlook:
Extension of services already rendered.

11. Conctact: The Secretary, Andhra Mahila Sabha, Mahila Sabha Building, University Road, Hyderabad 500 960.

12. Reference: SEIO, UNICEF, "Catalogue of Agencies Reaching Poorest Women in India."

Note: No information on items 4,5,7,8, and 9.

No. 2
Rural Devlp.
Andhra Pradesh

Arogyavaram Development Society, Madanapalle Taluk, Chittoor District, Andhra Pradesh.

I. Started: in 1974.

2. Coverage:

350 villages.

3. Activities:

a. Education

b. Family life

c. Health care, MCH

d. Irrigation

e. Setting up of co-operative societies for farmers; population studies, etc.

f. Soil conservation; demonstration farms; sericulture.

g. Protected drinking water facilities

4. Personnel and Training:

a. The Society maintains close association with various faculties of the Venkateswara University and the Medical College of Tirupati.

b. The Project Administration is headed by the Project Manager, assisted by the Assistant Project Manager, the Accounts Officer, and other Administrative staff. The technical staff comprises an Agronomist, Engineer, Veterinary Assistant Surgeon, Chief Medical Coordinator and Business Manager.

5. Supervision and Records:

The Health Programme is supervised by a team of Medical Officers who visit the sub-centres as per a fixed monthly schedule.

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No. 2
Rural Devlp.
Andhra Pradesh

6. Community and Other Participation:

Patients make a token contribution to the health programme. In other areas also, public contribution in cash and kind is encouraged.

7. Sponsorship and Funds:

Sponsored by the Government of India and Andhra Pradesh; and financed by the German Agency Evangelische Zentralstelle Fur Entwicklungshilfe (EZE).

8. Evaluation:

Evaluation teams are appointed for periodic assessments; Personal evaluation is made from time to time by senior officials of EZE from Bonn. Regular internal assessments are also carried out by the various administrative bodies of the ADS.

9. Problems:

a. Initial unwillingness to accept proposals for development work; later surmounted by continued educational programme.

b. Initial inability of poor villagers to contribute to the programme; later, enthused into coming forward with labour and kind, if not cash.

IO. Outlook:

a. Increase in milk production;

b. effort to make demonstration farms self-supporting;

c. proposals to organize the workshop in the Workshop Complex into an Industrial Engineering Cooperative Society.

II. Contact:

Project Manager; Arogyavaram Development Society, Madanapalle (A.P.)

I2. Reference:

"Profile of Arogyavaram Community Development Project"; VHAI.

No. 3
Health/C.D.
Andhra Pradesh

Indo-Dutch Project for Child Welfare, Hyderabad.

1. Started in 1969

2. Coverage:

Chevella block of Ranga Reddy district (pop. 1,17,000) was first fully covered: confined to four subcentres covering a population of 46,000 in 47 villages of the block. Now covering all SCs under MPW scheme.

3. Activities:

a. Health - regular medical care; mobile health team.

b. Immunization.

c. Distribution of nutrition supplements (locally prepared mix).

d. Economic activities for Mahila Mandals such as preparation of protein mix and spice packets; plus other typical activities.

e. Experiments with different types of pre-school education programme (balwadis, nursery schools).

f. Smallscale dairy and poultry units for villages.

g. Establishment of creches, nutrition demonstration units, vegetable and fruit gardens.

h. Family planning.

i. MPW Scheme:

Beginning in September 1976, block has 24 subcentres with 1 male and 1 female health worker per 5,000 population. This is one of the blocks selected for the new government MPW scheme.

j. Mother teacher training course. To encourage local mothers to assume responsibilities for child welfare. Some of the successful trainees have been appointed as Asst. Balsevikas or as craft teachers in the mahila mandal.

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No. 3
Health/C.D.
Andhra Pradesh

k. Other developmental schemes - handicrafts, youth clubs and intensive cattle development.

l. Workshops and seminars for exchange of information and training have increased since 1976. Short courses have also been organised in collaboration with other agencies and Departments as well as by the Project itself.

m. 60 teachers were selected to undergo a 10-day training course in the revised Primary School Curriculum. Practical training was provided in 6 selected schools.

4. Personnel and Training: (7 staff plus postgraduates under a Professor of Social Paediatrics).

a. Health team under a Prof. of Social Paediatrics from a city college visits the SCs twice weekly, for delivery of health services and for training ANMs and doctors in the programme.

b. PHC/SC staff: ultimate objective is for those to take over the centre work; all ANMs are given a population of 5,000 each. Intensive courses dais have been held.

c. Special BDO is stationed with the project.

d. The Grama Swasthika Experiment (Woman Village Health Agent) was started in February 1977. Instead of depending only on Government Health Workers, it was decided to encourage local initiative and participation in order to strengthen the MHW scheme. A 40-day training course has taught them maternal care, health and nutrition education. This training course is supplemented with periodic refresher courses each month.

5. Supervision and Records:

a. The systematic reporting system is based on simplified growth cards and family folders plus registers.

b. Monthly meetings are held at the block level.

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No. 3
Health/C.D.
Andhra Pradesh

c. An Expert Committee was appointed to critically examine the Primary School Curriculum and suggest ways of revising it.

d. Eleven meetings of the Expert Committee were held and a working group of field workers, representatives of class-room teachers, specialists in Telugu language, mathematics, science and social studies as appointed.

e. One lecturer from the State Council for Education Research and Training was allotted to each of the six schools for supervision and guidance.

6. Community and Other Participation:

a. Mahila Mandals actively participate.

b. Parents; participation in the form of partial contribution to the cost of nutrition and in the expenditure of the balwadis has risen. This shows that for the first time an effort has been made to make parents realize their responsibility in programmes for pre-school children.

7. Sponsorship and Funds:

The Netherlands Foundation and GOI, Health Ministry are co-sponsors. Funding is by the foundation with government and institutes' specialized staff.

8. Evaluation:

a. A longitudinal study by the College of Home Science studied the progress of the children.

b. The National Institute of Rural Development conducted the overall evaluation; baseline studies were done by them earlier.

c. The Niloufer Health Team has changed its role to monitoring, guidance, evaluation and training in the Multipurpose Health Workers' Scheme (MHWS) along with the doctors of the PHC.

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d. Sets of proformas for evaluation of the teachers' performance in practice teaching, reactions of the teachers and supervisors to the training programme and assessment of physical facilities and improvements suggested were prepared and supplied to each supervisor during the practice - teaching period of the Primary School Teacher trainees.

e. A 5-member Evaluation Committee with the Director of the SCERT as Chairman and representatives of the NCERT, CIE and the District Educational Officer, Hyderabad Dt., as members, was formed to monitor and evaluate the scheme as a whole and the revised curriculum in particular.

f. The Evaluation Committee chalked out a programme for regular visits to the schools and also preparation of evaluation criteria. The Committee met again on II.I.77 at which the Director, Indo-Dutch Project, reviewed the steps taken to implement the scheme.

9. Problems:

a. Attitudes of people to participation in view of dependence on government.

b. Too vast an area for each worker.

c. Considerable delay in the Government's decision to take over 2 balwadis each year in a phased manner.

d. There is still a wide communication gap, especially among the women regarding the need and utility of balwadis.

e. Rural women have always felt that they have no say in the matter and have kept aloof.

f. A major problem has been the large percentage of drop-outs (nearly 80%) at the primary school stage mainly because of the curriculum and its treatment.

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No. 3
Health/C.D.
Andhra Pradesh

g. A lack of practical training and experience on the part of the balsevikas.

h. The work of the health workers was hindered by inadequate supply of drugs.

i. The existing Mahila Mandals have restricted themselves to activities that do not interest the average village women.

IO. Outlook:

a. To improve the rural health schemes and to utilise the services of the MHWs in a more efficient manner, it is proposed to encourage a new VHW in each village. These women of some standing with at least 5th grade level of education, will be given a one-month training by the Niloufer health team.

b. The jobs assigned to them will be:

(i) Providing a list of pregnant and lactating mothers;

(ii) identifying children suffering from malnutrition; and

(iii) providing first aid in cases of emergency.

Simple records for these VHWs to be able to provide necessary vital information to HWs and the medical staff visiting the village, will be designed.

c. A Vigyan Mandir (Centre for Learning) to be established at Shankerpalli. The youth has come forward with a building for this purpose; they are also collecting funds to share the cost of setting up a library and museum.

d. The revised Primary School curriculum is to be implemented in 20 schools in the Project area; also in Classes 3 and 4 in the next academic year.

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No. 3
Health/C.D.
Andhra Pradesh

e. Based on the experience gained on the Chevella Experiment, a new practical and community-oriented urban pilot project has been designed in collaboration with the Dept. of Health, Municipal Administration in Hyderabad City in Ward I9 and Blocks I and 2 of Ward 20.

f. It has been decided to establish a new organization, "Kutumba Vikas Kendra" to be represented by 80% women and 20% men. The Panchayat, Panchayat Samiti and the Department of Women and Child Welfare will have their representatives on the executive committee of this Centre. All members will be trained by the Project, especially in skills of management and supervision. This body will have sub-committees to run and supervise each scheme, viz. Grama Swasthikas, creches, balwadis, economic projects, etc. In this way, it is hoped to get rural families to realise the importance of participation and sharing.

II. Contact:

Dr H.W. Butt, Director of Indian Bureau,
Indo-Dutch Project, 6-3-885, Somajiguda, Hyderabad
500 004 (A.P.).

I2. Reference:

Paper presented at the National Symposium, I976;
the Annual Report for I976; and paper presented
at the National Conference on the Evaluation of
PHC Programmes, I980.

No. 3a.
Health/C.D.
Andhra Pradesh

Indo-Dutch Urban Project for Child Welfare, Hyderabad

I. Started: in I976

2. Coverage:

Two Blocks of Ward 20 and five Blocks of Ward I9 in the old city of Hyderabad with a total population of 57,I57 and a total number of II,526 families.

3. Activities:

a. Integrated health assurance - spreading health education and preventive measures with the help of a trained ANM at the doorstep.

b. Creches for children in the age group of I to 2-I/2 years - to help and improve their nutritional and health status and to use them as tools to educate mothers in child-rearing practices, nutrition, health and hygiene.

c. Pre-school education; balwadis; Mother teachers' training courses.

d. Bal Gyan Kendra (Non-formal education centres).

e. Vigyan Mandirs (Centres of learning); youth clubs for the age group I2 to 20 to improve their knowledge, skills and attitude, through informal methods of learning and recreation.

f. Mahila Mandals - programmes for the age group I2 to 20; recreational, educational and economic projects; adult literacy.

4. Personnel and Training:

a. A part-time doctor and ANMs provided by the Department of Health and the Municipal Corporation.

b. Voluntary lady doctors attend to children at the creches and balwadis.

c. The College of Nursing has deputed three staff nurses once a week to give on-the-spot guidance and training to ANMs.

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No. 3 a.
Health/ C.D.
Andhra Pradesh

d. Two trained mother teachers for each creche in each Block.

e. Voluntary workers for the Bal Gyan Kendra.

f. Craft teachers from the community for Mahila Mandals.

g. The Mother Teacher Training Course has on its staff members from the College of Home Science, College of Nursing, Niloufer Health Team, etc.

5. Supervision and Records:

a. Trained ANM makes regular home visits and periodical check-ups.

To back up the ANM, a part-time doctor is available at the Composite Unit for complicated diagnosis and advice and to refer such cases to an appropriate hospital.

b. A home scientist trained in food and nutrition from the College of Home Science, visits the creches once a week to check diet and maintain a case history record for each child.
Two lady doctors visit the creches on a voluntary basis to supervise the health and immunization requirements of creche children.
Progress cards are maintained and detailed records of immunization and follow-up are entered on them.

c. "Balwadi" children who "graduate" to local primary schools are followed up periodically by community organizers and mother teachers to find out their progress.

6. Community and Other Participation:

a. For the Integrated Health Assurance Plan, each family is expected to subscribe 10% of the total cost of individual care amounting to Rs. 20 to Rs. 25 per annum per family of five members.

b. Parents also contribute to the other programmes of the Project.

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c. The Nizamia Women's Education Centre, College of Home Science, Niloufer Health Team are some of the organizations which participate in the programmes by providing training, promoting discussions, preparing the syllabus, etc.

d. Government departments, institutions and voluntary agencies are proportionately involved according to their interests and role in urban community development. International agencies like UNICEF and CARE have also come forward to help. Some other collaborating agencies are :
The Municipal Corporation of Hyderabad; Department of Health and Family Welfare; Department of Preventive Medicine; College of Nursing; College of Home Science; Department of Industries; Hyderabad Urban Development Authority; Mobile Creches, New Delhi; Population Education Centre; Department of Education; State Health Educational Bureau; Jawaharlal Nehru Technological University; Bharatiya Grameen Mahila Sangh, etc.

7. Sponsorship and Funds:

When the Project was started, the sharing of costs was about 60% by the Indo-Dutch Project and I0% each by the Municipal Corporation of Hyderabad; Government Departments; Institutions/Agencies; and the Community. Subsequently, there has been a decrease in the Project share, and a corresponding increase in the share of agencies and communities.

8. Evaluation:

a. Regular monthly meetings are held, at which mother teachers, helpers and other Project staff report details of each plan and present any problems faced by them.

b. Case history cards have been designed to study the impact of pre-school education on the health, education and general behaviour of the "balwadi" child.

c. Individual progress cards are prepared for each balwadi child to provide information on health, education, family size, etc. periodically.

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No. 3 a.
Health/ C.D.
Andhra Pradesh

9. Problems:

a. A major problem faced in enrolling families in the Integrated Health Assurance Plan, was that inspite of the willingness shown, the families were hesitant to pay their share of the cost for the entire year.

b. In the plans to immunize children under ten, most parents do not bring their children for the second or third dose. Even during home visits, the ANMs have found it difficult to complete the immunizations as prescribed.

c. Sometimes the Municipal Corporation Health Staff cover the families for immunizations, and in several cases, the second and third doses are completed by them, for which no proper records are kept.

d. In regard to the "creche" programme, parents continuously stress on the helper fetching their children from their homes to the creche each day.

e. Problem of dropouts - in creches as well as balwadis - due to illness, leaving the locality, or non-payment of contribution.

f. Rivalry between the Pardhis and Harijans, which made the latter community unwilling to send their children to the balwadi which was located at Pardhiwada.

g. Irregularity and untidiness. All these problems are being gradually overcome.

IO. Outlook:

Organization of a "community education programme" to educate the community in all spheres of development of the child; and to obtain a feed-back for the plans implemented so far.

II. Contact:

Dr H.W. Butt, Director of Indian Bureau, Indo-Dutch Project, 6-3-885, Somajiguda, Hyderabad 500 004.

I2. Reference:

Annual report.

No. 4.
Health and C.D.
Andhra Pradesh

Rayalaseema Development Trust, Anantapur.

I. Started in I969.

2. Coverage:

I4 clinics serving 70,C00 population.

3. Activities:

a. Nutrition and immunization for under fives;

b. Nutrition education;

c. Safe water supply;

d. Mother care; child care centres;

e. Illness care;

f. C.D.

g. Housing;

h. Drilling of wells;

i. Aid for construction of schools;

j. Food for work programmes.

4. Personnel and Training:

Each clinic has a doctor, ANM and ayah.

The health staff works in the area as a team, with the Doctor in charge of the main centre as the leader of the team. The Coordinator coordinates the various health activities at different levels.

5. Supervision and Records:

a. Constant and adequate supervision in the nutrition programmes;

b. The economy of hospitals and immunization programmes are monitored every month at various levels;

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c. Village Health Committee officials meet once in two months; informal meetings are held when necessary.

6. Community and Other Participation:

a. Beneficiaries and participants contribute to the welfare funds of the Trust, which lays stress on active participation by the community and pursuance of the principles of self-reliance.

b. Farmers have contributed considerably to the Wells Programme.

c. The people of the Federal Republic of Germany are collaborating in these programmes.

7. Sponsorship and Funds:

Rayalaseema Development Trust; Central Agency, West Germany; EZE, Germany.

8. Evaluation:

Yearly evaluation by separate staff; upto IO% of total funds spent on the evaluation programme.

9. Problems:

a. The same children do not eat the food provided regularly; elder children accompanying them, sometimes eat up food which is meant for the younger ones;

b. Unless there is constant vigil, stocks of food do not reach the villages on time;

c. Difficulties encountered during immunization programmes include suspicions that any mass innoculation or mass treatment has something to do with sterilization, because of the family planning programme being high on the priority list.

d. Difficulty in recruiting suitable staff.

e. Caste structure in villages prevents participation by Harijans and women at group meetings. If a 'balsevika' is a Harijan, other communities do not want to come to her or give her accommodation. If she belongs to a 'forward' caste, she takes no interest in the Harijans.

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No. 4
Health and C.D.
Andhra Pradesh

IO. Outlook:

a. Starting of training programmes in Home Science for village girls.

b. Training programmes for village mid-wives and medical practitioners in villages.

II. Contact:

Father Vincent Ferrer/Capt. Ashok J. Tipnis, Rayalaseema Development Trust, Bangalore Highway, Anantapur, A.P.

I2. Reference:

Annual Report; VHAI

No. 5
Rural Development
Andhra Pradesh

Village Reconstruction Organisation, Guntur

I. Started in I969

2. Coverage:

50 villages, mostly in Andhra Pradesh, but a few in Orissa and Tamilnadu also.

3. Activities:

Construction of houses, health, agriculture, education, nutrition and village leadership training.

The VRO objective is towards remaking and adapting rural village communities in such a way as to make them viable and complementary to the urban development. Has worked in cyclone-affected areas.

4. Personnel and Training:

Volunteers, mostly graduates trained in the field as well as in formal courses. Training of various types pre-service, in-service, extension etc. are given.

6. Community and Other Participation:

Programmes start with decision taken by the community. The projects organizational structure is matched by a corresponding one for the village.

7. Sponsorship and Funds:

Over 30 agencies have pooled together responsibility and funds for VRO. VRO contribution is 30%, governments 50% and public's I5%.

8. Evaluation:

Research has just been started with some in-depth socio-economic studies.

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No. 5
Rural Development
Andhra Pradesh

9. Problems:

Government funds are channelled through various departments and hence not available in time. The social climate is not easily amenable to development.

II. Contact:

Professor M.A. Windey S.J., Director, 6/9 Brodipet, Guntur 522 002.

I2. Reference:

M.A. Windey, " A Rural Reconstruction Movement in India", paper presented at the Seminar on Development Projects Designed to reach the Lowest Income Groups, Paris, June I974.

Note: No information on items 5 and I0.

No. 6
Health and Rural Dev.
Andhra Pradesh

Bhagavatula Charitable Trust, Yellamanchili.

1. Started: In 1977

2. Coverage: 50 villages; 6000 population of agricultural labourers, cultivators and artisans of the area.

3. Activities:

   a. Farmers' Service Centre, which has promoted dairy and poultry activity among small and marginal farmers;

   b. Training in dairying and poultry for women;

   c. School, run by the Zilla Parishad;

   d. Cattle cross-breeding;

   e. Minor irrigation;

   f. Adult and non-formal education;

   g. Afforestation; small industries and appropriate technology;

   h. Women's welfare; immunization;

   i. Drinking water provision.

4. Personnel and Training:

   VHWs are trained and work in the Community Health Programmes in nine villages.

5. Supervision and Records:

   Work done by VHWs is supervised by trained village youths and health visitors.

6. Community and Other Participation:

   Local telent is utilized to muster local resources to solve problems; opportunity is afforded to generate local leadership.

7. Sponsorship and Funds:

   The Bhagavatula Trust; some voluntary donations.

No. 6
Health and Rural Dev.
Andhra Pradesh

10. Outlook:

a. The Trust wishes to expand its activities and implement many schemes with the close cooperation of the Government.

b. Schemes include development of ground water resources;

c. Cottage industries for village artisans.

11. Contact:

Dr. B.V. Parameswara Rao, Secretary, The Bhagavatula Charitable Trust, Yellamanchili - 531 055, Visakhapatnam District (A.P.)

12. Reference:

"Catalogue of Agencies Reaching Poorest Women in India". Trust Secretary's note.

NOTE: No information on items 8 and 9.

No. 7
Community Development
Andhra Pradesh

Comprehensive Rural Operations Service Society (CROSS), Hyderabad.

I. Started: In 1975

2. Coverage:

Weaker sections, especially Harijans in 65 villages in Bhongir, Alair and Mothkur blocks in Nalgonda District of A.P.

3. Activities:

a. Agriculture; land development; soil conservation

b. Irrigation

c. Animal husbandry; veterinary services

d. Cottage industries; loans for weavers, etc.

e. Health - preventive, curative, referral, first-aid

f. Non-formal education (night schools)

g. Community organizations - leadership training; youth clubs; village associations.

7. Sponsorship and Funds:

A secular, voluntary organization, CROSS receives grants from Bread for the World and E.Z.E., West Germany; and loans from commercial banks, GOI and other local resources.

II. Contact: Secretary, CROSS

a. House no. 47, Snehapuri, Nacharam, Hyderabad 501 507. — Administrative Office.

b. Bhongir - 508 116, Nalgonda District (A.P.) — Executive Office.

NOTE: No information on Items 4,5,6,8,9,10 and 12.

No. 101
Health
Assam

Total Health Care Project, Tamulpur Block, Kamrup District, Assam.

1. Started in 1976

2. Coverage:

Tribal (and other backward communities) population of 1,33,000 in 204 villages of the block.

3. Activities:

The project aims at providing various basic health services like Family Planning, Primary vaccination, immunization, malaria survey attending to minor ailments, control of TB, leprosy, etc.

4. Personnel and Training:

This block has been divided into 5 zones. Each zone will have a doctor in charge supervising the work of roughly 8 units. Each unit will be headed by a para-medical worker who could be a vaccinator, a health assistant, an ANM, a basic health worker, a sanitary inspector, a leprosy worker, a BCG vaccinator or a smallpox vaccinator. The person in charge of each unit would be responsible for total coverage of about 3 villages of population around 300 families.

12. Reference: EIO, UNICEF

Note: No information on items 5 to 11.

No. I02
Science Education
Assam

Assam Science Society, Gauhati, Assam.

I. Started in early I960 (or may be earlier)

2. Coverage:

Entire Assam. Membership is from University, colleges and schools. There are Science Clubs and Science Societies affiliated to it.

3. Activities:

a. Publishers two journals (one for college level and the other for school level).

b. Brought out Assamese terminology of scietific terms. Published several books on Science in Assamese.

c. Organization of popular lectures in schools/ colleges, organization of Science Clubs, Science Fairs and Science talent search and organization of museum for children.

d. Organization of local science societies at different places affiliated to it.

7. Sponsorship/Funds:

This is a voluntary organization with grants from State Government and other agencies.

I2. Reference: EIO, UNICEF

Points 4-6 and 8-I2 not applicable.

No. I03
Women's Welfare and
Rural Development
Assam

Gram Lok Seva Sangh, Dt. Kamrup.

I. Started: In I976 - 77.

2. Coverage:

I3 villages; I7,000 population, many of whom belong to scheduled tribes.

3. Activities:

a. Providing training and employment to 900 spinners and 35 weavers.

b. Adult education.

c. Vocational training for men in pottery, carpentry, blacksmithy, agriculture.

d. Irrigation and drinking water facilities.

6. Community and Other Participation:

Local people are involved in the implementation of programmes as well as decision-making.

9. Problems:

a. Supply of both cotton and silk yarns is a major problem; at present, there is a shortage of yarn; cotton yarn being imported from Madhuri; and silk from Karnataka.

b. Many rural households in Assam have facilities for cocoon cultivation in a small way; but this is not enough to make the weaver self-sufficient.

c. Marketing is also a problem.

I0. Outlook:

a. Establishment of Mahila Samitis in all nearby villages;

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No. I03
Women's Welfare and
Rural Development
Assam

b. Sericulture development by increasing the production of silk worms in kitchen gardens.

c. Linking of raw material growth with processing and marketing.

II. Contact:

Dwarika Barua,
Gram Lok Seva Sangh,
P.O. Niz Dhamdhama, Dt. Kamrup,
Assam.

I2. Reference:

"Catalogue of Agencies Reaching Poorest Women in India".

NOTE: No information on items 4, 5, 7 and 8.

No. 201
S.R.D.
Bihar/MP

Agricultural Community Development Project - "Krishi" Samudayik Vikas Yojna, Palamau (Bhandaria Block) Bihar and Surguja, M.P.

I. Started: In 1968

2. Coverage:

Rural population of 50,000 in 100 villages.

3. Activities:

Rural Health, Agricultural Extension Work, Subsidized seed, Fertilizer, Education, Trucking, Irrigation, Relief Agency.

a. Started with leprosy work - now has over 500 patients all over Surguja and Palamau. Provides monthly clinics in various locations in Palamau; three mobile clinics.

b. Has "clinic" with in-patient facilities.

c. Serves as agency to co-ordinate relief work.

d. Makes local roads - provides truck for outside markets.

e. Flour mill - oil mill (small).

f. Pump rental - tractor rental.

g. Workshop service - repairs.

h. Small agricultural school.

i. Mobile Cinema.

6. Community and Other Participation:

Run entirely by "local" tribal population.

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No. 201
S.R.D.
Bihar/MP

7. Sponsorship/Funds:

Received some outside capital - but now runs from profits made on two "Farms" owned by the project - no outside funding. Secular - non-profit.

I2. Reference:

UIO UNICEF note.

Note: No information on items 4, 5, 8 - II.

No. 301
Health
Gujarat

Bochasan Gujarat Blind Relief and Health Association (GBRHA), Chikhodra.

1. Started: In 1950; present programme started from 1975.

2. Coverage:

Present programme covers a rural population of approximately over 1,00,000 in 20 villages of Kaira District, Gujarat.

3. Activities:

a. Trachoma control; trachoma prevention in school children.

b. Eye clinics.

c. Mobile eye camps (for cataract and curable blindness)

d. Health/Nutrition Education - a link between malnutrition and Vitamin A deficiency.

e. Undertakes relief operations on behalf of the State Government whenever called for.

4. Personnel and Training:

a. A President, two Secretaries and 4 members look after the management of the Association.

b. Honorary eye surgeons, doctors, social workers are associated with the activities.

6. Community and Other Participation:

Local villagers and organizations from other districts also give donations.

7. Sponsorship and Funds:

a. This organization was founded purely voluntarily by a social worker, Mr. Ravi Shankar Maharaj, with the main objective of "restoring sight to the blind and preventing blindness in the sighted".

...

No. 301
Health
Gujarat

b. Financial support from International agencies like OXFAM, Royal Commonwealth Society for the Blind, U.K. Swiss Aids; Direct Relief Foundation, U.S.A. ; Lions Clubs - Australia; Jayam, Belgium; and Misereor, Germany.

10. Outlook:

a. Control Programmes - out-door clinic to treat 50,000 patients annually; indoor 100-bed hsspital.

b. Special clinics for - squint in children; retinal diseases; eye bank for cornea grafting; spectacles bank.

c. Prevention Programmes - mass survey in villages; health education through leaflets, slides, exhibition etc; malnutrition project for children; and vaccination project.

11. Contact:

Dr. R.R. Doshi, Honorary Secretary and
Eye Surgeon, GBRHA,
Eye Hospital, Chikhodra, (via Anand) 388 320,
Dist. Kaira, Gujarat.

12. Reference:

WIO, UNICEF Note
pamphlet published by GBRHA

Note: No information on items 5, 8 and 9.

No. 302
Health
Gujarat

Baroda Citizens Council, BARODA

I. Started in I964

2. Coverage:

Urban community of Baroda; and since I97I, leprosy affected persons in Sarasia Colony of Baroda.

3. Activities:

a. Assists the Municipal Corporation and other voluntary agencies in their health programmes - in I976, motivated about 2,700 people to get inoculated.

b. Held domonstration of food and nutrition specially meant for the economically weaker sections.

c. Pre-mother training programme.

d. Library and book bank facilities.

e. Adult education classes.

f. 5 balwadis were opened.

g. Training programmes for supplementing income.

h. Youth development programmes, which include "interview clinic programmes", training in personality development, leadership camps, etc.

i. Identification and training of volunteers to be later placed with agencies where their services could be utilized.

j. Self employment services like making loans available for various trades through banks.

k. Programme of Leprosy control for which a "Shram Mandir Trust" was established towards the socio-economic medical rehabilitation of leprosy patients. For this leprosy cases are detected through Surgey and Health Education programmes; regular treatment is given at an outdoor clinic.

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No. 302
Health
Gujarat

1. To discourage begging and encourage productive work, Ambar Charkhas were distributed and a Workshop started.

m. Research and Publications Wing of the Council undertakes social science research; also publishes "vadodara Vikas" (a monthly) to cover activities of the different wings of the Council.

4. Personnel and Training:

26 staff members besides the Chairman of the Council. These include para medical workers, part-time medical officers and community organizers. Chairmen of the different committees are chosen from among these.

6. Community and Other Participation:

Various samitis, corporations, State Government institutions, industries and trusts give financial and other support to the council.

7. Sponsorship and Funds:

a. Though this is exclusively run by the citizens of Baroda, the Council receives its funds from various sources, like member Industries of the Federation of Gujarat Mills and Industries, Baroda, OXFAM, U.S. Department of Health Education and Welfare, MISEREOR, the Indo-German Social Service Society, the German Leprosy Relief Association, Hind Kusht Nivaran Sangh, UNICEF, the Indian Institute of Public Administration.

b. Many banks have joined hands with the Council in the implementation of its employment and income generation schemes.

c. The M.S. University of Baroda.

d. Two charity trusts and voluntary and social organizations.

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No. 302
Health
Gujarat

8. Evaluation:

The Council has a special Research Wing to evaluate the work done by the Council Staff; to analyse the feed-back given by the staff and indicate areas of future work.

IO. Outlook:

a. The resettlement programme for leprosy patients envisages residential facilities, a medical community centre, school and dormitories for children, workshops.

b. Industrial and agricultural activities including both training and production will be carried out.

c. This Leprosy Control Programme aims to change Society's attitude towards leprosy and to educate people about the scientific facts of the disease.

II. Contact:

Rashmin Lakhani, Member Secretary and Executive Director, Baroda Citizen's Council, Above Health Museum, Sayaji Baug, Baroda 390 OI8; Shri Ramanbhai B. Patel, Chairman.

I2. Reference:

Annual Report, I976, Baroda Citizens Council; and the Council's pamphlet on Leprosy, "Shram Mandir" brought out on the eve of the All-India Leprosy Worker's Conference held at Baroda.

NOTE: No information on items 5 and 9.

No. 303
Research
Gujarat

Centre for Regional Development Studies (CRDS),
Nanpura, Surat.

I. Started in 1969

2. Coverage:

Rural and urban areas, primarily in Gujarat, but also in other parts of the country.

3. Activities:

a. Support to institutions for carrying out research in social sciences.

b. Establishes welfare services centres to undertake welfare activities for children and adults in rural and urban areas.

c. Organizes relief work in normal times and times of calamities.

d. Trains research workers and people for welfare activities.

e. Studies activities covering areas of social, economic, and political development.

f. Encourages perspective studies in Institutional development and social reform.

g. Hosts conference and seminars for the furtherance of the above objectives.

h. Has completed 20 research projects like "Study of Family Planning Programme of Amerely Dt."; "Untouchability in Rural Gujarat"; "Study of Social Strata in Tribal talukas of Bharuch and Panchmahal Districts", etc.

4. Personnel and Training:

Governing Board has 7 members, including the Director. There are also 5 faculty members and 3 administrative staff workers.

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7. Sponsorship and Funds:

The CRDS receives regular maintenance and development grants from the Indian Council of Social Science Research (ICSSR) and an equal matching maintenance grant from the Gujarat Government annually. Project expenses come out of specific grants from the ICSSR, Bureau of Economics and Statistics, Gujarat Government, several district Boards, Municipalities and Planning Commission. For some other projects, the CRDS uses its own resources.

IO. Outlook:

The CRDS will deal with 8 more projects in its effort to bring to light important facts pertaining to social problems and behaviour. Some of them are:

a. Re-study of social and economic conditions of Chodhra - an aboriginal tribe of Gujarat.

b. Preparation of All-India Reports on ICSSR National Study on Educational Problems of scheduled tribes and scheduled castes, students.

c. A tribal community in urban setting; case study of Dhodia in Surat district.

d. Education and social change of Malav Village of Panchamahal district.

e. Energy use pattern of middle level rural families in Gujarat, etc.

II. Contact:

Dr I.P. Desai, Director, CRDS, P.O. Box 38, Dangore Street, Nanpura, Surat - 395 001 (South Gujarat)

I2. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda.

Note: No information on items 5, 6, 8 and 9.

No. 304
Women's Welfare
Gujarat

Self Employed Women's Association (SEWA)
Gandhi Majoor Sevalaya, Ahmedabad

I. Started: In 1972 - Trade Union;
1975 - Mahila Sewa Trust.

2. Coverage:

Women labourers in Ahmedabad; has spread to Bhavnagar (handloom weavers).

3. Activities:

a. Banking: Formation of a Co-operative Bank (Sewa Bank) to protect women vendors from exploitation by private money lenders.

b. Social Security Services.

c. Productivity programmes.

d. Research.

e. Legal aid.

f. Maternity benefit.

g. Tubectomy benefit.

h. Death benefit.

i. Widowhood benefits.

j. Spectacles benefit for middle-aged women.

k. Health checking Camp was organized with the help of 40 doctors.

l. Day Care Centre - Palnaghar (Cradle Home) for children of vegetable vendors.

m. Training classes for sewing, embroidery and knitting in the labour areas.

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No. 304
Women's Welfare
Gujarat

4. Personnel and Training:

a. A squad of I4 volunteers looks after the work of recovery of loans given to the SEWA members by the SEWA bank.

b. To provide legal aid whenever required, SEWA has requisitioned the services of a lady lawyer.

c. Fourteen officials look after the various activities of the organization. They are a President, two vice-presidents, one general secretary, two joint secretaries, a treasurer and 7 Executive Committee members.

7. Sponsorship and Funds:

SEWA receives finances from the Central Government and the State Government through TLA (Textile Labour Association): and its own membership fees.

9. Problems:

Since the Bank deals with very poor women like garment workers, used garment dealers, hand cart pullers, vegetable vendors and junk smiths, the pass-books are not always preserved carefully by them; they are either lost, stolen or defaced.

IO. Outlook:

a. Wants to explore possibilities of providing low cost housing.

b. Plans for vegetable cooperatives with women managers and members, to be run on lines similar to Amul.

c. Wants to set up a rural marketing centre as a link between urban consumers and the rural population.

d. Wants to organize women from other trades in Ahmedabad and surrounding areas.

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No. 304
Women's Welfare
Gujarat

II. Contact:

Ms. Ela R. Bhatt, General Secretary, SEWA.

I2. Reference:

Reports on "Voluntary Agencies" (Working in the Field of Community Development and Housing) - Prof. M.B. Achwal, Director, "Heart", Baroda, and Ramakant Jamdar, Secretary, "HEART", Baroda, 390 001.

NOTE: No information on items 5, 6 and 8.

No. 305
Community Development
Gujarat

Vedchhi Pradesh Seva Samiti, District Surat

1. Started: In 1964, though the idea of the Vedchhi Intensive Area Scheme was formed in 1948 by a group of social workers under Shri Jugatram Dave.

2. Coverage:

   a. Valod Taluka, 40 villages - 5,500 people under Antyodaya.

   b. The residents of Valod Taluka - men, women and children - many of whom are tribals and fall below the poverty line.

3. Activities:

   a. Integrated Area Planning with special emphasis on Antyodaya - serving those below the poverty line - special programmes for these families, such as land improvement, animal husbandry, artisan training, small-scale business, health and nutrition.

   b. Cooperatives for stone-quarrying and crushing; bamboo work; palm juice collection, etc. There are Cooperative Sales Depots as well.

   c. Education - Primary and Secondary schools, adult education.

   d. Small-scale industries - to provide training in making hand-made paper, bricks, carpentry, printing, metal work, khadi and village industries, etc.

   e. Development Schemes : agriculture, dairy, poultry, health and sanitation, diamond polishing, etc.

   f. Special programmes for women : Lijjat Papad Centre where over 500 women are members and earn a steady income; sewing carpet-making; dairying and poultry farming.

   g. 'Janata College' : provides specialised training to women in child rearing, nutrition, house decoration, health, family planning and crafts.

4. Personnel and Training:

   a. 30 centres for organization of programmes; each centre is manned by a "Mukhya Karya Karta" and a number of other workers.

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No. 305
Community Development
Gujarat

b. The centres have a total of about 150 paid and trained workers.

5. Supervision and Records:

a. To supervise the activities of the centres, there are three sub-committees : education, Khadi and Village industries, and a cooperative under 'Yojana Samiti' which is accountable to the Trustee Board.

b. Valod Pappad-rolling centre : Here in all matters regarding the daily functions of production, scheduling, marketing, deployment of personnel, the decisions are taken and implemented by the professional team of managers and supervisors at the Centre. Long term policy decisions are taken by the Managing Committee at its quarterly meetings.

c. The salaried staff of the Valod Centre is headed by a Manager in overall charge of the unit. There are 2 women supervisors to check each stage of the production process; and 6 women distributors-collectors to record dough collection and 'pappad ' delivery by each member daily. Also, a supervisor makes a door-to-door inspection of the premises of the pappad roller regularly to ensure that members conform to a minimum standard of hygiene and cleanliness.

6. Community and Other Participation:

a. The Samiti aims at using local talent at all levels, thereby creating and encouraging village leadership and initiative.

b. Women come together with their problems at "camps" and "Shibirs" and themselves try to work out ways of solving them.

7. Sponsorship and Funds:

Sources of finance are : bank loans, income from production, Government grants, donations from the people and charitable agencies.

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No. 305
Community Development
Gujarat

8. Evaluation:

a. The accountants of each of the 30 centres meet once a month to take stock of the month and prepare accounts;

b. A meeting of all workers takes place once in a quarter;

c. Supporters and sympathisers of the programmes, beneficiaries and workers meet once a year - usually on the 26th of January - to discuss the policies and programmes of the organisers.

9. Problems:

a. In the making of "khakara" - a thin bread which is dried and can be preserved for a long time - marketing is a problem, as it is an entirely new product.

b. The sewing activity in the Buhari centre saw some problems initially. After purchasing the machines and training women, orders did not come in. Gradually however, the centre has started receiving orders, especially for school uniforms.

c. Carpet making, which is essentially a man's job, had a problem in that enough labour was not available to unravel the wool after it came from the dyers. The problem was partially solved when women were given this particular job; but it is still a tedious job and cannot be done fast.

10. Outlook:

a. The organisers wish to identify all families below the poverty line and promote special development schemes for them. The plan is to cover the entire Valod District.

b. Lijjat Papad Society is to diversify range of products to enable more women to join the organisation. 'Masala' preparations have already been started. Agarbattis (incense sticks) and leather goods to follow.

11. Contact: Allubhai Shah, Vedchhi Pradesh Seva Samiti, Vedchhi, Taluka Valod - 394 640, Dist. Surat(Gujarat).

12. Reference: "Catalogue of Agencies Reaching Poorest Women in India"; "New Partnership in Rural Development" by D. Paul Chowdhry; and "Income Generating Activities for Women".

No. 501
Health
Himachal Pradesh

Village Health Workers Scheme, Lady Willingdon Hospital, Manali.

1. Started: In 1974

2. Coverage:

Five villages of a total population of about 1,000 - North-east of Manali.

3. Activities:

a. Basic health care to backward and remote villages.

b. Teaching VHWs about malnutrition in under-fives and their remedies, ante-natal and post-natal care, care of newborns, immunization, family planning and management of simple illnesses and common infectious diseases.

4. Personnel and Training:

Five women (average age of 19-20 years) were trained as VHWs at the base hospital every Thursday morning. On alternate Wednesdays, the doctor visited their villages and involved them directly in his work within the village. They participated in various clinics.

5. Supervision and Records:

Each VHW was given a note book to maintain a record of T.B. patients and their treatment; ante-natal cases, along with the record of the total village population.

6. Community and Other Participation:

Villagers contribute towards the financial support of VHWs. They have also provided a place in the Central Village for the Clinic and training of VHWs.

7. Sponsorship and Funds:

Sponsored by Lady Willingdon Hospital, Manali, under the guidance of Dr. B.M. Laugesen of VHAI, New Delhi. No specific funds are available. Expenses are met through the main hospital funds and some voluntary donations.

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8. Evaluation:

After one evaluation, it has been found that of the five VHWs who started their training, three are still working. The villagers go to the VHWs with their complaints. Under the VHW's supervision, T.B. patients are more regular with their treatment, VHWs also get called for deliveries at home. All this shows that villagers are developing confidence in them.

9. Problems:

a. Cooperation of villagers was initially difficult to get, because village elders objected to their women folk going out for training;

b. VHWs' feeling of inferiority regarding their poor education and lack of confidence in their ability to learn and retain what they learnt;

c. The panchayat did not initially entertain the idea of each family paying Re I/- per month towards payment to the VHW.

d. Organizational problems and limited staff made it impossible for the doctor-in-charge of the scheme to spare more than one day per week for the VHW scheme. There were also transportation problems.

e. The scheme did not have separate funds; so even the smallest expense would disturb the main set-up of the hospital budget.

IO. Outlook:

The plan is to introduce the VHW in the 64 villages of Manali Valley, which are I6 km. either way from the hospital.

II. Contact:

Project Director, Lady Willingdon Hospital, Manali I75I3I, Himachal Pradesh.

I2. Reference:

Paper presented at the National Symposium, I976; VHAI.

No. 701
Health
Karnataka

Mallur Health Co-operative.

I. Started: in 1973

2. Coverage:

The community of Mallur and other member villages of the co-operative numbering 4,000 to 5,000.

3. Activities:

a. Personal Services

i. Curative Clinics (daily OPDs)

ii. Maternity and child health services- both at clinic and domiciliary (under 5 clinics are domicillary)

iii. School health services for village schools.

iv. Immunization programmes

v. Detection, treatment and follow-up of major diseases.

vi. Motivation for family planning

vii. Specialist camps at Mallur

viii. Hospital referrals

ix. Family record maintenance.

b. Community Services

i. Chlorination of well water

ii. Popularization and construction of sanitary latrines, soakage pits, and advice on environmental sanitation

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No. 701
Health
Karnataka

iii. Collection of health data through periodical surveys.

iv. Co-ordination with Government health personnel in national health programme

v. Health education at group and village levels.

vi. Nutrition education and nutrition supplementation programmes.

Members of the Mallur Milk co-operatives get the above services free, while non-members pay for drugs/dressing and minor surgery. All preventive and promotive work is free to both categories.

4. Personnel and Training:

a. Medical Officer - I

b. ANM - I

c. Clerk - I

d. Compounder - I

e. VHW - I

5. Supervision and Records:

a. The female workers were given annual refresher courses in the teaching hospital maternity ward.

b. Periodical meetings of the Health Advisory Committee under the chairmanship of the Mallur Milk Cooperative are held, where all matters are discussed.

6. Community and Other Participation:

The health co-operative committee includes the chairman and secretary of the Mallur Milk Co-operative, representatives of the St. John's Medical College, of the Bangalore Dairy, the State Health Services, and the medical officer. 45% of the villages covered are members of the Mallur milk co-operative.

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Hence the community leaders are actively involved in the planning and organization of the co-operative. Also the youth association, the Young Farmer's Association, the Mahila Mandal and the panchayat take part in the activities. Paramedical workers are drawn from the community and trained for community health work. The recurring costs of the health co-operative are borne by the milk co-operative either as a levy on milk production by members or for extra expenditure by the co-operative itself. Involvement of school staff has also been good.

7. Sponsorship/Funds:

Apart from the above community sources, the VHAI, the Catholic Bishops Conference of India and St. John's Medical College sponsor the project. At first the MMC and Bangalore Dairy financed the scheme with some inputs from the medical college, now MMC alone does so.

8. Evaluation:

A project has been taken up to study the effect of the scheme on morbidity and mortality statistics.

9. Problems:

a. Improvements are needed in the quality of promotive and curative services. Simpler skills, cheaper drugs and intermediate technology to suit rural conditions must be devised.

b. Improvement of education including health education through VHWs must be attempted.

IO. Outlook:

a. St. John's Medical College has been considering project proposals to use the experience of the Mallur experiment to strengthen the Government Health Care Delivery System through the Primary Health Centre.

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No. 701
Health
Karnataka

b. The State Bank of India has sponsored a project to upgrade the Government SCs of the Dommasandra PHC (allotted to St. John's Medical College) into mini-primary health centres by posting interns and linking them with the PHC's and teaching hospitals through or referral services complex.

c. Side by side, a development team will identify resources and organize cooperative schemes in the village, which can eventually take over the costs of supporting the doctors and SCs. This process will be carried out in a phased manner in 3 to 5 years and later, will be extended to the Integrated Rural Development Scheme of Anekal Taluk.

Project proposals for both S.B.I. and IRD Schemes of Anekal Taluk have been drawn up and the former is actually in progress.

II. Contact:

Maj. Gen. B. Mahadevan, Prof. and Head of the Department of Community Medicine, St. John's Medical College, Bangalore 560034.

I2. Reference:

Paper presented at the National Symposium, 1976; and National Conference on Evaluation of PHC Programmes 1980.

No. 702
Health
Karnataka

Medicare, Kasturba Medical College Hospital, Manipal.

I. Started: In 1972.

2. Coverage:

Medicare (a comprehensive medical and dental health service) is one of the four broad areas into which the hospital's extension services are divided. The other three areas are:
b. Ophthalmic and Dental Camps;
c. School health care;
d. Rural maternity and child welfare homes.

a. Medicare : is of 2 types - (i) Institutional and (ii) Community Welfare Service.
In (i) institutions covering members and their families are the beneficiaries;
In (ii) 3 panchayats and the lower socio-economic section of Udupi Municipality are benefited. Population covered in all the schemes of Medicare is around 48,000.

b. A total of over 20,000 patients have been covered in the ophthalmic and dental camps.

c. All schools in the neighbourhood are covered in the school health care programme.

d. There are 7 rural maternity and child welfare homes, which are run at distances of 3 to 20 miles from the hospital. These centres act as a base for family planning advice to the rural population.

3. Activities:

a. Under the Medicare Scheme, the activities are manifold:

(i) Consultation, examination and advice.
(ii) Laboratory tests.
(iii) X-rays.
(iv) Electro-cardiogram.
(v) Operations, confinements, hospitalization, dental service, etc.

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No. 702
Health
Karnataka

b. In the ophthalmic and dental clinics, patients are examined in camps and those needing operation are brought to the base hospital.

c. Under the school health care programme, medical, ophthalmic, dental and ENT care are provided to students.

d. Each of the 7 rural maternity and child welfare centres has six beds for delivery with supporting facilities. A team from the hospital visits each centre once every week.

4. Personnel and Training:

a. Manpower is provided by the Medical College. Both staff and students work on these various programmes.

b. The team for the maternity and child welfare schemes consists of a lady Medical Officer, health educator, social worker, a paediatrician and 6/7 students.

6. Community and Other Participation:

a. Sponsoring bodies like service organizations, Panchayats, etc. provide transport, publicity, drugs, etc.

b. For the School health care programme, one rupee is collected from each child and given to the hospital.

7. Sponsorship and Funds:

a. The Medical Relief Society (private) runs the rural maternity and child welfare homes.

b. The Royal Commonwealth Society for the Blind has provided a grant which roughly covers transport and medical expenses for the ophthalmic camp programme.

c. Equipment and technical personnel are provided free by Kasturba Medical College Hospital.

d. Boarding and lodging of patients and propaganda work are taken care of by local welfare organizations like the Lions Club, Rotary Club, etc.

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No. 702
Health
Karnataka

9. Problems:

a. Coordination between different agencies responsible for health care and development has been difficult.

b. Transport costs; two-wheelers for younger personnel may be the answer.

c. Tendency to prescribe costly/sophisticated treatment needs re-training of health care personnel.

d. Often, the root cause is poverty; health will improve in such cases only when the general economic condition improves.

IO. Outlook:

a. Child welfare homes are being expanded; on out-patient service with an intern and a doctor is envisaged.

b. Intensive health education and action to cover major diseases.

c. Safe water supply and sewage disposal with the help of panchayats.

d. Intensification of pest control measures.

e. Intensification of family planning programmes.

f. Prophylactic immunizations to cover the entire population of surrounding areas.

II. Contact: Dr. A. Timmappaya, Medical Superintendent,
Kasturba Medical College Hospital,
Manipal 576II9, Karnataka State.

I2. Reference:

Paper presented at the National Symposium on Alternative Approaches to Health Care, I976; brochure published by Kasturba Hospital, Manipal.

Note: No information on items 5 and 8.

No. 703
Rural Development
Karnataka

Syndicate Agriculture Foundation, Manipal.

I. Started: In 1966 ; Farm Clinic Project of the Foundation was established in 1973.

2. Coverage:

Farm Clinic Project covers 1304 families in Barkur Panchayat of Udupi Taluk in South Kanara. Villages covered are Hosala, Hanehalli, and Kachur.

3. Activities:

a. Children's education - with aid from Government of Karnataka has set up a nursery school at Hosala, especially for scheduled caste and scheduled tribe c children - provides free lunch and clothes to nearly 50 children.

b. Extension Education programmes.

c. Provides input supplies to farmers like seeds, fertilizers, plan protection materials, poultry feed, etc.

d. Provides consumer service on hire-equipment like sprayers, pumpsets, etc.

e. Health maintenance, house construction, crop production, irrigation development, land improvement, animal husbandry.

f. Provides aid in setting up vocations like dairy, tailoring, carpentry, bee-keeping, poultry farming etc.

g. Arranges regular health check up programmes, even in the interior villages to enable the poor, illiterate villagers to get medical facilities at their doorstep.

h. Farm Clinic Projects, which promote the above programmes as integrated rural development projects - these have been extended to the states of A.P.,Kerala, Tamil Nadu, Maharashtra, U.P., M.P., and Punjab.

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i. Mobilises the efforts of rural people to take up community service like family planning, literacy campaigns, MCH, tank rejuvenation, etc.

j. A special scheme of the Project known as "Efficient Management Technique for Small Farm"(EMTSF), was launched in 1974 for the beeefit of marginal/sub-marginal farmers - to take up cultivation, maximise agricultural production and minimise expenditure.

k. Setting up of "New Farm Information Exchange Clubs; and "Future Farmers' Clubs" for students.

l. Publications - "Krishiloka" in Kannada; "Karshakalokam" in Malayalam; "Krishilokam" in Telugu.

m. The foundation has been identified by GOI as a recognized institution to take up training of rural youth under the "National Scheme of Training Rural Youth for Self-Employment" (TRYSEM).

4. Personnel and Training:

a. Syndicate Agriculture Foundation : The management is looked after by the Governing Council comprising the President, Vice-President, Treasurer, Executive Director, Secretary, two Joint Secretaries and 13 members.

b. Farm Clinics : Trained Field Assistants who work under the guidance of the Branch Manager and Farm Representative of Syndicate Bank branch to which their 'Clinic' is linked.

c. Training Programmes : The services of Veterinary Scientists from Agricultural Universities, Department of Animal Husbandry and Bee-keeping Society, and the Khadi and Village Industries Commission are availed of for the training programmes of the Foundation.

d. "Farm Representatives" who are agricultural graduates employed by Syndicate Bank, work in the massive credit and development programmes called "Supervised Agricultural Credit Schemes".

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5. Supervision and Records:

a. Constant supervision is one of the basic components of EMTSF. Small and marginal farmers cultivate their land under the direct supervision of the Project personnel.

b. Syndicate Bank branches are actively involved in identifying, financing and guiding trained entrepreneurs.

c. A firm of Chartered Accountants from Coondapur audit the accounts of the Foundation annually.

d. Farm Representatives assist by following up on the proper use of credit given to farmers.

e. Introduction of the "Agricard" system to enable holders of such cards to buy their requirements of inputs from authorized dealers. The agricard establishes a ready means of credit for the purchase of these inputs.

f. To give proper guidance to the Farm Information Exchange Clubs and Future Farmers' Clubs, the Governing Council of the Foundation sends members on frequent visits to the Clubs.

6. Community and Other Participation:

a. Dairy training camps in collaboration with Canara Milk Producers' Cooperative Union Ltd.

b. Close association with the Indian Dairy Association in organising extension activities for Dairy farmers.

c. Six Regional Rural Banks have been sponsored by Syndicate Bank to collaborate with the Foundation in implementing rural development activities.

d. The University of Agricultural Sciences, Bangalore; Departments of Agriculture, Horticulture and Sericulture; KVIC; Bombay; and other national and international voluntary organizations participate in different aspects of the Project.

e. Kasturba Medical College, Manipal, helps to conduct medical check ups in villages.

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No. 703
Rural Development
Karnataka

f. MCH Programme - assisted by CARITAS INDIA and local Mahila Mandals.

7. Sponsorship and Funds:

a. The activities are supported to a large extent by Syndicate Bank, which makes funds available through its Agricultural Finance Department.

b. Some other agencies which participate in various programmes of the Foundation by contributing funds or technical skill are:

the Government of Karnataka; CODP, Mangalore; CARITAS INDIA; Ford Foundation; Department of Animal Husbandry; KVIC; etc.

c. Voluntary organizations like Lions Club, Rotary Club, Jaycee's, M/s Salgaonkar, M/s Space Age Precision Tools Pvt. Ltd., Pune, also donate for specific programmes.

8. Evaluation:

a. An evaluation of the "Efficient Management Technique for Small Farm" showed that extra employment opportunities were created. The evaluation was done by collecting relevant information for four months from all families covered by the scheme.

b At an Inter-Club Meet of Future Farmers' Club, the activities of the individual clubs were reviewed and evaluated.

9. Problems:

a. Most farmers are economically handicapped and fatalistic, and do not possess the requisite technical and managerial ability. They are unable to exploit resources to obtain various supplies and services adequately and in time.

b. There is no adequate irrigation facility and digging of wells is costly for a farmer with a small holding. Therefore, caution is required for motivating farmers to go in for irrigation wells.

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c. About 40 per cent of the land is undulating and barren. So, it has to be levelled before cultivating. This is costly and will also disturb the top soil layers, impairing fertility.

d. The large number of under-employed males and females can be diverted to suitable subsidiary occupations to supplement income, but this needs prior training, credit and marketing facilities.

e. A sizeable number of target clients are illiterate, adhere strictly to traditional norms, and lack understanding of the significance of education; so all children of school going age are not sent to schools.

IO. Outlook:

a. Training of rural youth under TRYSEM to be continued on a larger scale.

b. Plans to organize more audio-visual programmes for a larger number of groups on topics like rural health education,sanitation, etc.

c. More Farm Information Exchange Clubs to be set up.

d. "Krishiloka" monthly journal to be published in Hindi.

e. More decentralization of Foundation functions envisaged in order to reach larger numbers of farmers.

f. At the request of the Manipal Industrial Trust, which has received a Ford Foundation grant for rural development, Syndicate Agriculture Foundation is to implement the project for three years upto 1983.

g. Training in bee-keeping to young boys to be expanded.

h. A mini pilot plant to produce cement from paddy husk is to be set up with financial cooperation from the National Research Development Corporation. This is expected to provide employment to about 30 people.

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No. 703
Rural Development
Karnataka

II. Contact:

The Secretary,
Syndicate Agriculture Foundation,
Syndicate Bank Building,
Manipal 576 II9, Karnataka State.

I2. Reference:

Booklets published by the Foundation; Annual Report, I980.

No. 80I
Health
Kerala

Cooperative Rural Dispensaries, Kerala.

1. Started: In 1972.

2. Coverage:

Each dispensary covers one panchayat; there are 59 such dispensaries in the State distributed in all the districts.

3. Activities:

a. The dispensary is a self-contained medical unit for both curative and preventive care.

b, An inpatient ward with 8 beds is provided.

c. It has a clinical laboratory for routine tests.

d. The pharmacy attached to the dispensary dispenses medicines at fair price.

e. Cooperative hospital societies.

4. Personnel:

Each dispensary employs:

a.	Medical Officer	- I
b.	Nurse	- I
c.	Pharmacist	- I
d.	Technician	- I
e.	Manager-cum-Accountant	- I
f.	Attenders	- 2

5. Supervision and Records:

The board of directors manages the affairs of the dispensaries. A cooperative society has overall control.

6. Community and Other Participation:

The scheme has government as well as community involvement, the latter due to the cooperative management.

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No. 80I
Health
Kerala

7. Sponsorship and Funds:

The schemes is run by the state government. But medicines, consultation fees and tests are paid for by the community.

8. Evaluation:

A sample of 6 rural dispensaries and a few beneficiaries were selected for in-depth study to evaluate the impact of the scheme in I973 - 74 and I977 - 78.

9. Problems:

a. Uncertain and not-too-attractive service conditions for doctors, as they are not regular government employees.

b. Lack of proper guidance and supervision from the medical department, the cooperative dispensary being treated as a step-child of the cooperative department.

c. Frequent change of doctors and para medical staff and long period of absence before replacement is made.

d. The cooperative dispensaries often face deficit of income over expenditure because charges collected from the rural poor are negligible.

e. Lack of own buildings; inadequacy of funds to procure all medicines; inability to sell medicines at concessional rates because dispensaries buy them from the nearby medicine stores;

f. Inadequate water supply, electricity and transport facilities; lack of laboratory facilities.

g. The hospital societies are not able to render the necessary services to the cooperative rural dispensaries because of lack of organizational link between the two.

IO. Outlook:

a. Extension of Cooperative District Hospitals in all districts are revamping the existing ones.

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No. 80I
Health
Kerala

b. To make their membership more broad-based to attract more resources.

c. To introduce all major departments and specialities in the district hospital, which would also have a well-equipped laboratory, X-ray, physiotherapy units, and pharmacy.

II. Contact:

Dr. M.V. George, State Planning Board, Rajalakshmi Building, Pattom, Trivandrum -4.

I2. Reference:

Paper presented at the National Symposium, I976; and National Conference on Evaluation of PHC Programmes, I980.

No. 802
Science Education
Kerala

Kerala Sastrasahitya Parishad, Trivandrum

I. Started: In 1963 (Active from 1966)

2. Coverage:

Kerala State. Membership at the beginning was 40 and by now has grown to 2,000 regular members and 2,000 student members. There are 1,500 + affiliated science clubs and societies. The "impact population" is estimated at 50,000 families.

3. Activities:

a. Publishes three science journals for upper primary, secondary and college levels.

b. Mass popular Lecture Programmes in 1973 (1,200), and again in January 1976 (12,000) - on Nature, Society and Science.

c. Establishment of school science clubs and science societies.

7. Sponsorship and Funds:

The organization is based purely on voluntary effort.

10. Outlook:

Activities being planned or yet in an embryo stage include science academies, science centres and rural science forums and their inputs to improved village technology.

11. Contact:

Dr. M.P. Parameswaran, Chintha, Trivandrum 1.

12. Reference:

Brochure and Report of the Society.

Note: No information on items 4, 5, 6,8 and 9.

No. 803
Nutrition
Kerala

Pre-School Health and Nutrition Programme of Kerala - Ten Year Plan

I. Started: In 1975 (also the composite programme for women and pre-school children).

2. Coverage:

400 villages throughout Kerala, beneficiaries - over 52,000.

3. Activities:

a. 657,384 mal-nourished pre-school children and pregnant and lactating mothers are receiving supplementary meals daily under the joint on-going programme.

b. Monthly health chek-ups, immunization, treatment for parasites and health education are being provided.

c. "One meal a week per month" programme has been introduced.

d. Villagers of the 400 villages have constructed 400 nursery schools.

e. Each nursery school has a beneficiary strength of 100 pre-school children. The older ones attend day-long nursery classes and receive 2 supplementary meals daily.

f. All severely mal-nourished children are fed twice daily.

g. 30 pregnant and lactating mothers also receive one meal a day and health assistance.

h. Immunizations comprising DPT, BCG and Polio are given on schedule; also the necessary treatment of parasites, Vit. A and iron deficiencies.

i. Twice a year, 2 day women's camps for nutrition and health education are held. Lectures, and visual aids are given. Negative and positive health practices are demonstrated.

j. By 1979, 1600 nursery schools were in operation reaching 208 thousand mothers and pre-school children.

No. 803
Nutrition
Kerala

5. Supervision and Records:

Local medical officer examines the children on a monthly basis and individual records of the examinations are kept.

6. Community and Other Participation:

a. Local community involvement is encouraged. The people contribute money and materials required for the feeding programme of the local school for one day a week, or one day in the month, under the "one meal a week per month" programme.

b. For each centre, the community has given the land and Rs. 3,000/- for cultivation.

7. Sponsorship and Funds:

This integrated health and nutrition programme has been developed by the Kerala Government and CARA, so also the Composite programme for women and pre-school children. Local involvement is seen in both. Besides local contribution, the State Government pays Rs. 3,000/- and the balance is paid by CARE.

10. Outlook:

a. Aims to eradicate malnutrition among pre-school children by 1985. For this supplementary food and medical support will be given to every malnourished child in Kerala after birth.

b. The health of the pregnant and lactating mother will be monitored and she and her infant will receive the necessary health inputs to ensure a proper beginning in life.

c. Before 1985, over one million children will receive this total health package.

No. 803
Nutrition
Kerala

I2. Reference:

"Community Level Approaches to Health and Nutrition" (As possible ways to reach populations which are difficult to cover by centrally designed and operated government programmes) /- by Dr Rajammal P. Devadas, Director, Head and Professor of Nutrition, Sri Avinashilingam Home Science College for Women, Coimbatore.

NOTE: No information on items 4, 8, 9 and II.

No. 901
Health
Madhya Pradesh

Padhar Hospital Community Health Project
Padhar P.O., Batul District.

1. Started: In 1975.

2. Coverage:

A 10 km. circle around Padhar comprising 82 villages and a tribal population of about 36,000 are the target group.

3. Activities:

a. Home visits including relevant health education.

b. Treatment of minor illnesses with sale of medicines.

c. Vitamin A doses given to deficient cases on the spot.

d. MCH services in hospital OPD, plus immunization and health education in OPD and wards.

e. School health services with medical, dental and eye check-ups.

f. Proposed soil testing facilities and good seeds at cheap rates.

g. Community development through agricultural extension, poultry, dairy, fishing, farming, etc.

4. Personnel and Training:

a. Hospital Employees including a senior nurse, a lab. technician-cum-driver, health educators and an ANM. Other staff join periodically.

b. Village Health Workers and traditional attendants/ dais are being trained.

5. Supervision and Records:

So far 14 VHWs have been trained and established in the villages. Every month they provide village-wise information on births, deaths, at risk children, new cases of malnutrition, morbidity, pregnancies, etc.

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No. 901
Health
Madhya Pradesh

6. Community and Other Participation:

VHWs to be paid by own villages (50 p. per household p.m.) through perhaps the Panchayat. The Dai will be paid in the traditional way by the family she serves.

7. Sponsorship and Funds:

The Evangelical Lutheran Church of M.P. is sponsoring the project through Padhar Hospital. The Christoffel Blinden Mission (CBM) of Germany is providing the basic fund for a three year project. CBM is particularly concerned with the work of preventing blindness and the rehabilitation of the blind.

8. Evaluation:

Daily and weekly team meetings and base-line surveys followed by a re-survey focussing on cases of malnutrition, Vitamin A deficiency and scabies.

In December 1979, the Programme was evaluated by the Research and Evaluation Section of the Christian Medical Association of India Community Health and Family Planning Project (CMAI CH and FP) Bangalore.

9. Problems:

a. Morale of team working on low pay and difficult conditions.

b. Suspicion of the Gonds who have been exploited for generations.

c. Negative attitude to family planning.

d. Resistance to change.

e. Taboos affecting health and nutrition.

f. Non-acceptance of CHWs, this problem partly arising from socio-cultural conditions.

g. Natural calamities (droughts and famines) and lack of timely medical help due to lack of communication; poor crop yield, poor quality cattle and hens; low yield of milk, eggs, etc.

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No. 90I
Health
Madhya Pradesh

10. Outlook:

The present project is a pilot one. Ground-work for expansion is already being undertaken.

11. Contact:

Dr. E. Arthur, Director, Padhar Hospital,
Community Health and Development Department,
P.O. Padhar, Batul Dist. (M.P.)

12. Reference:

Paper presented at the National Symposium, 1976; and paper presented at the National Conference on Evaluation of PHC Programmes, 1980.

No. 902
Child Care
Madhya Pradesh

Kasturba Gandhi National Memorial Trust, Indore, Madhya Pradesh

I. Started: In 1945

2. Coverage:

Being a national level organization, this Trust has branches almost all over India and its activities cover people in remote villages, especially women and children.

3. Activities:

a. "Training camps" for preparing "Gram Sevikas" to penetrate remote villages were organized in Borivali (Bombay), Mysore and Maharashtra; and the first institute for this was started in Madhubani (Bihar) in 1946.

b. With the starting of maternity training in its own hospitals in 1954, Auxiliary nurses, midwives, gram sevikas and Shanti Sena workers were trained.

c. Besides the refresher course camps for child education, nutrition and strengthening Trust work in villages, Village Women's Camps were started in 1950.

d. The Trust has established Rural Service Centres, Health Service Centres, Composite Centres and Nutrition Balwadis to provide milk and bread to children.

e. Works for community hygiene, village sanitation and treatment of patients.

f. Runs hospitals in Andhra Pradesh, Madhya Pradesh and Tamil Nadu, the last especially for the care of leprosy patients.

g. Runs an "Ashrama" for destitute girls in Durgapur (M.P.), Bal Ashrama in Orissa, and a Balghar at Kasturbagram (Tamil Nadu); has also opened "Kanya Ashramas", Balwadis and nurseries in different states.

h. The aboriginal girls' home at Niwali is one of the major projects of the Trust.

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i. Has set up centres to give training in agriculture and village industry.

j. It publishes a quarterly in Hindi.

k. Undertakes the following special activities at Kasturbagram: ANM training; family and child welfare training; setting up of balwadis; basic middle school, rural institute, music section, a 25-bed hospital, out-patients' department and mobile dispensary, weaving department, mixed farming on 300 acres and 'Goshala'; library and information centre, khadi bhandar and Consumers' Co-operative Store.

l. An International Women's Year Camp was organized in 1975, in which 2562 women from 456 villages participated.

m. "Stree Jagran" (awakening among women) camps were held in Assam through padyatras.

4. Personnel and Training:

There are 24 Trustees on the Board, of whom 5 are Holding Trustees and 12 are Members of the Executive Committee; 17 provincial "pratinidhis" (provincial governesses for constructive work) in 17 states.

6. Community and Other Participation:

The Trust was set up with donations by about a million people; further participation by local communities is encouraged.

7. Sponsorship and Funds:

The Trust raises finances through donations from leading industrialists, Central and State Government grants, some foreign agencies and through the projects themselves.

8. Evaluation:

The Trust has published a booklet on the "Report of the Assessment and Evaluation Committee" in English.

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No. 902
Child Care
Madhya Pradesh

10. Outlook:

One of the Organization's main aims being "Stree Shakti Jagran", it plans to awake enormous woman power. With this end in view, it continues to impart to rural women training that encourages them to become self-reliant.

11. Contact:

Smt. Vishakha Mehta, Joint Secretary, Kasturba Gandhi National Memorial Trust, P.O.: Kasturbagram, District Indore 452 001. Madhya Pradesh.

12. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda.

Note: No information on items 5 and 9.

No. 903
Child Care
Madhya Pradesh

Madhya Pradesh Ravimahasangh (MPRS), Jabalpur

I. Started: In 1966

2. Coverage:

SC/ST/Backward classes in the economically backward areas of Jabalpur.

3. Activities:

a. Established kindergartens for the 3 to 6 age group - takes these children on educational tours.

b. It runs 2 women welfare centres - Late Minimata Women Welfare Centre and Indira Gandhi Women's Welfare Centre - where training in child development, home science and cottage industries is given.

c. Has started an Adult Literacy Centre, the Govind Choudhary Memorial Library and the Shri Babu Jagjeevan Ram Library.

d. 3 youth welfare centres.

e. Has appointed a special enquiry panel to investigate cases of injustice and exploitation against socially backward people and submits regular reports to the Government so that suitable action may be taken against offenders.

f. Publishes the monthly 'Ravi Jyoti' to cover its activities.

g. In 1971, it planned a "Jagjeevan Ram Samajvad Griha Nirman Scheme" to provide cheap houses to the economically weaker sections of society.

4. Personnel and Training:

The general body of the organization consists of 10 full-time members; 9 part-time workers and a few women workers.

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No. 903
Child Care
Madhya Pradesh

6. Community and Other Participation:

A large group of sincere and hardworking people participate in its activities. It gets good response from the youth and adults like advocates, professors, executives and ministers of both State and Central Governments.

7. Sponsorship and Funds:

Receives grants from the State Government. For its Low Cost Housing Scheme, it received a grant from the Department of Harijan Welfare of the Madhya Pradesh Government.

9. Problems:

Inadequate cooperation and insufficient grants from G.O.I. and the government of Madhya Pradesh are hindering the welfare work of the Sangha amongst Scheduled Castes and Scheduled Tribes in M.P.

IO. Outlook:

In the second phase of its housing scheme, the Sangha has planned to construct a colony of 25 residential units, of which 9 have already been completed.

II. Contact:

Shri Ganesh Prasad Ahirwar, Chief Secretary, M.P. Ravi Mahasangha, I, Jagjeevan Nagar, Medar Tekri [illegible]
Jabalpur - 462 OOI (M.P.)

I2. Reference:

"Reports of Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda; Annual Report of the Sangha.

No. 904
Education
Madhya Pradesh

Kishore Bharati, Hoshangabad

I. Started: In 1972.

2. Coverage:

Over 90 villages; Science Teaching Programme (STP) covers whole of Hoshangabad District through middle schools.

3. Activities:

a. Experimenting in rural education for village conditions.

b. Non-formal education; literacy; Science Teaching Programme.

c. Cattle development.

d. Agricultural extension and research.

e. Cottage industries.

f. Irrigation.

g. Health education and research.

h. Cooperatives.

4. Personnel and Training:

Ten paid workers and a large number of voluntary workers; Professional staff from the State Government, Universities and other national organizations are deputed to work with them in different schemes.

6. Community and Other Participation:

Different people/institutions in various blocks of over 16 villages are asked to prepare text books and science kits suited to their particular environment.

7. Sponsorship and Funds:

Voluntary organization with no foreign financial aid; volunteers raise funds through donations and State grants.

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No. 904
Education
Madhya Pradesh

8. Evaluation:

a. In-depth analysis during the past seven/eight years has been done by a group of dedicated people with different professional background.

b. Comparison of its experiences with those of Government and other voluntary agencies has been undertaken.

9. Problems:

Most of the educational and development activities benefit, and thus strengthen, mainly the middle level and richer farmers, and thus help to widen the poverty gap.

IO. Outlook:

a. Youth organization and non-formal education;

b. Consolidation of Science Teaching Programme.

II. Contact:

Anil Sadgopal, Village Palia Piparia,
P.O. Malhanwada, Dt. Hoshangabad 461 990 (M.P.)

I2. Reference:

"Catalogue of Agencies Reaching Poorest Women in India" prepared by the Institute of Social Studies;
"New Partnership in Rural Development" by D.Paul Chowdhry.

Note: No information on item 5.

No. 905
Health and C.D.
Madhya Pradesh

"Anand Nagar" Leprosy Rehabilitation Project, Dhar

I. Started: In 1976, as part of the multi-dimensional rural extension service (known as CIRDA - Centre for Indigenous Rural Development and Awakening) of the Canadian Mission Hospital, Dhar.

2. Coverage:

44 families of leprosy patients belonging to 6 districts of three states, M.P., Gujarat and Rajasthan. Initially, the Rehabilitation Project covered 50 needy children of Dhar town; the present idea is to cover more beneficiaries, especially those from surrounding villages.

3. Activities:

a. Development of land for agriculture, gardening, pisciculture, etc.

b. Digging of tube-wells for irrigation and providing water supply to the settlement.

c. Building of a community centre and an administrative - cum-OPD Block and houses for leprosy patients.

d. Fostership and scholarship programmes for their children and other needy children.

e. Development of poultry, piggery, animal husbandry, cottage industries, etc.

f. Development of bio-gas plant, solar-heater, sun-basket, etc.

g. Extension services for leprosy control and eradication.

h. Hostel for 50 handicapped children.

i. Experimental semi-urban school with special emphasis on career, craft and human development.

j. An experimental rural school at the Anand Nagar project site - also lays emphasis on craft, vocational training and human development.

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No. 905
Health and C.D.
Madhya Pradesh

k. Nutritional programme for children and lactating mothers and others (250 people) assisted by CARE/Department of Tribal Welfare, Government of Madhya Pradesh.

4. Personnel and Training:

a. Some of the staff and beneficiaries themselves are being trained.

b. The semi-urban school at Dhar town is run by a staff of 12.

5. Supervision and Records:

a. The Project has its own supervisory staff.

b. Some beneficiaries are being trained as trainee supervisors.

c. Overall supervision is by the Canadian Mission Hospital, Dhar Management Committee.

6. Community and Other Participation:

a. As this is a self-help project for tribals suffering from leprosy, there is full participation from them in the planning, execution and management of the programme.

b. Other participating agencies are Satya Sai Sewa Samiti, Arya Samaj, Rotary Club, Municipal Council, Masihi Sewa Mandal (Canadian Mission in Malwa Area), Department of Tribal Welfare, Government of Madhya Pradesh.

7. Sponsorship and Funds:

a. The sponsorship programme (for 50 children) is supported by Actionaid;

b. The Leprosy Rehabilitation-cum-training Centre has initially been funded by OXFAM and the Canadian Mission - CIDA;

c. Other projects are aided by different local, Governmental, and international agencies;

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No. 905
Health and C.D.
Madhya Pradesh

d. Assistance has also been received from R.C. Church, Dhani.

8. Evaluation:

a. Regular evaluation exercises are carried out by the Project authorities;

b. Field directors of various other agencies also evaluate the Project work regularly.

9. Problems:

a. A typical tribal problem is that of drop-outs, because the tribal people are essentially nomads and get tired of doing anything on a regular basis;

b. Another problem is the paucity of good, dedicated personnel. Dhar is one of the most backward tribal districts in the country, with almost no housing facilities. It does not have even a single railway line ! Hence, the problem of recruiting appropriate staff;

c. Insufficient funds for the many more projects envisaged.

d. The agricultural economy of Dhar is poor due to the soil not being fertile enough. Agricultural produce is unable to support the tribals. So, for 6 months at least, there is little or no work, which is the reason why many tribals take to criminal activities. In fact, a number of tribal communities in the district are prrmanently branded as criminal.

e. Expansion of facilities is therefore urgently needed along with programmes for women and children as well; but non-availability of resources is a hindrance to the carrying out of future plans.

IO. Outlook:

a. Expansion of the Sponsorship programme;

b. Expansion of hostel facilities for handicapped children, so that at least 200 children are housed instead of the present 50.

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No. 905
Health and C.D.
Madhya Pradesh

c. Increasing the number of child beneficiaries from 50 to 300 with the inclusion of needy children in the surrounding villages covered by the Mission Hospital's Rural Extension Service.

II. Contact:

Dr R.P. Dass,
Medical Superintendent/Director,
Comprehensive Health and Community Development Programme,
Christian Hospital,
Dhar - 454 001 (M.P.)

I2. Reference:

Booklet on the Leprosy Rehabilitation Project;
information supplied by Director.

No. 1001
Rural Dev.
Maharashtra

Agricultural Institute, Kosbad, Maharashtra

1. Started: In 1949

2. Coverage:

Tribals of Thana district in particular, and small and marginal farmers.

3. Activities:

a. Education: residential schools, including work-experience, including fields such as poultry-keeping, kitchen gardening, carpentry as well as helping in agricultural work.

b. Training: A Tribal Youth's Training Centre for above activities.

c. Research in problems of agricultural production peculiar in the area.

d. Development: Adoption of 5 villages to demonstrate and develop the cultivation of improved crops etc. on a continuing programme.

e. Applied Nutrition Programme started in 1967 at the Village Level Workers' Training Centre of the Institute.

f. Seed production.

g. Feeding of children, expectant and nursing mothers.

h. Project for starting 10,000 nutrition gardens has been taken up.

4. Personnel and Training:

a. Training is given to rural youths, extension workers and school teachers.

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No. IOOI
Rural Dev.
Maharashtra

f. Mobile training squad to conduct training in the ANP villages.

6. Community and Other Participation:

Participation by Rural Development Department of Maharashtra Government since I967 and support by UNICEF, in the A.N.P. programme. National and international organizations, business firms and also individuals contribute to funds for different projects.

7. Sponsorship and Funds:

Gokhale Education Society, Maharashtra.

9. Problems:

a. Continued dependence on mono-crop system and age-old cultivation methods.

b. Rice crop is not cultivated scientifically. This results in poor yields.

c. Inadequate food does not allow them to put in hard labour.

d. Illiteracy because of non-attendance of children in school due to hunger.

e. Lack of refreshers' training. Trainees need refresher training every three years to keep themselves up-to-date in the latest techniques of horticulture, poultry, fishery, etc.

II. Contact:

Mr J.S. Patil, Principal, Agricultural Institute, Kosbad, Hill 40I 703, Dist. Thane, Maharashtra.

I2. Reference:

Mr J. Sommer et al (I974); Literature published by the Institute.

Note: No information on items 5, 8 and IO.

No. I002
Comprehensive Health
Maharashtra

Integrated Health Services Project, Miraj Medical Centre, Miraj, Sangli District.

I. Started: In 1973

2. Coverage:

The entire Miraj Taluka (936 sq. km.) comprising of 58 villages and a rural population of over 2.3 million.

3. Activities:

The Miraj Medical Centre.

By Female Staff

a. Maternal care.

b. Child care.

c. Family Planning

d. Medical Care (I/2 day daily)

e. Health Education (I/2 day daily)

f. School Health

g. Co-ordination of activities with Male Health Workers.

By indigenous 'Dais'

a. Hygienic deliveries.

b. Family Planning motivation.

c. Simple symptomatic treatment of minor ailments (some dais only - in villages without health centres).

By male staff

a. Detection of infectious diseases.

b. Vital statistics.

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c. Smallpox, Malaria, T.B. and Leprosy work; both detective and immunization etc.

d. Family Planning.

e. Environmental Sanitation.

f. Health Education.

g. School Health.

h. Treatment of minor ailments.

i. Cholera and Typhoid Innoculation.

j. Co-ordination of activities with female staff.

4. Personnel and Training:

a. Six medical officers (3 PHCs) in project area.

b. 4I male and 30 female, Government unipurpose health staff - six months training to convert them into Integrated Health Staff.

c. I73 (93% of all in area) dais - trained for tasks as above.

d. 40 local women trained to be part-time health assistants working for the ANMs.

5. Supervision and Records:

a. A system of continuous monitoring of data on all aspects has been operating.

b. A feedback system on a quarterly basis for the average worker and on a monthly basis for the weaker one is proving effective.

c. Direct and constant supervision in the form of education, guidance, help and problem-solving is used. Memos are replaced by problem-solving sessions with concerned workers.

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No.1002
Comprehensive Health
Maharashtra

6. Community and Other Participation:

Government and Zilla Parishad (District Council) participation exists since the project is utilizing their present infrastructures.

7. Sponsorship/Funds:

This is a joint project of the Government of Maharashtra Sangli Zilla Parishad and Miraj Medical Centre. Staff are paid by the first two. Extra input funds are provided by the World Council of Churches in Geneva.

8. Evaluation:

a. A baseline sample survey was conducted and a mid-term evaluation in the middle of the 3rd year.

b. Data on pre-project years is also available for comparison. Control areas are not easily available.

c. Hope to evolve an indigenous method of evaluation to compare the individual's performance as unipurpose health worker and as a multipurpose worker.

9. Problems:

a. Differential salary scales in the Government structure create problems when MPW scheme is started.

b. Loss of T.A. due to smaller area served in MPW scheme.

c. Lack of leave reserves in the first year.

d. Non-positioning of ANMs for a long time.

e. Resistance among older staff to new system.

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No. I002
Comprehensive Health
Maharashtra

f. Resistance among MOs to new pattern especially regarding visits to SCs to supervision of the staff, to preventive aspects, to training staff.

g. Transfers of trained staff.

h. Delay in follow-up of diagnoses leading to low morale.

i. The compaign approach does little to enforce integration.

j. Statewise shortage of vaccines, vitamin A syrup, iron and folic acid laboratory. Medicines invariably never reached SCs, reason given being that quota was too small even for the PHC.

II. Contact:

Dr Eric R. Ram, Project Director.

I2. Reference:

Paper presented at the National Symposium, I976; WIO, UNICEF.

Note: No information on item IO.

No. I003
Comprehensive Health
Maharashtra

Comprehensive Rural Health Project, Jamkhed, District Ahmednagar

I. Started: In January 1971.

2. Coverage:

Health services for approximately 80,000 people in 70 villages.

3. Activities:

a. Supplementary nutrition - one meal daily for deserving pre-school.

b. Immunization of all pre-school children - 80% coverage.

c. Provision of simple, minor illness care.

d. Maternal services.

e. Family Planning services including tubectomy and vasectomy.

f. Control of chronic illness.

g. Prevention of Blindness.

h. General public health measures - safe drinking water through tubewells, mass health education, general agricultural development to increase food production and thus nutrition.

i. Food for work programmes are being carried out with the food provided by CASA.

j. A hospital at Jamkhed with 30 beds has been provided; this hospital is also treating leprosy and T.B. cases.

4. Personnel and Training:

a. VHW - intensive training in health education, pre-school children care and maternal care.

b. Nurse.

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c. Health Centre Staff. The health team has an in-service training programme on a weekly basis.

The VHW is paid an honorarium of Rs. 30 to Rs. 50 per month for part-time work; and the nurse and Health Centre Staff are paid salaries comparable to government scales.

VHW's job also includes collection of vital statistics, assisting in surveys, and following-up of chronically ill patients.

5. Supervision and Records:

A mobile health team visits every village every week. This team consists of a doctor, a social welfare worker, ANM and an assistant. These teams carry out immunization, supervise the VHWs and provide necessary assistance. The VHW supervises the nutrition programme.

6. Community and Other Participation:

a. District level leaders are on the Advisory Committee for the projects.

b. Organization of Farmers Clubs; Supplementary nutrition of under fives and mothers is managed through these Clubs, but is supervised by the VHW.

7. Sponsorship and Funds:

This is a non-Government project, sponsored by the Marathi Mission, Bombay, and supported by voluntary organizations, which have donated some funds and equipment. Funds are also raised by local economic activities.

Initial funds for establishing the 30-bed clinic were provided by the parent body (Marathi Mission). The project raises more money from local persons through fees for curative services.

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No. I003
Comprehensive Health
Maharashtra

8. Evaluation:

a. Monitoring of reach of activities and periodic surveys. Evaluation of the work is carried out by VHWs, mobile teams and other personnel by house to house surveys etc.

b. The project has made a deep impact, especially in projecting the idea of a VHW. It has shown that even illiterate women can be properly trained into effective village health workers.

c. VHWs keep weekly reports of vital events, weight cards; list of immunized children, etc. At the Centre, there are master registers. The mobile teams also keep records of their activities.

9. Problems:

a. Quality of curative services provided are affected by use of lesser trained personnel and delegation of responsibility to them (but outweighed by preventive care possible).

b. Problem of caste consciousness - which was solved by working to re-orient the outlook of the women selected as VHWs and the community.

c. No serious effort has been made to involve women generally.

d. Environmental sanitation has not been tackled at the same time.

IO. Outlook:

The project is interested in expanding by training other workers to start similar projects elsewhere.

II. Contact:

Dr R.S. Arole, Director, Society for Comprehensive Rural Health Projects in India, P.O. Jamkhed, Dt. Ahmednagar, Maharashtra.

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No. I003
Comprehensive Health
Maharashtra

I2. Reference:

a. Paper presented at the National Symposium I975, and National Conference on Evaluation of PHC Programme I980.

b. "Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A joint UNICEF/ WHO study.

c. A note on Comprehensive Rural Health Project, Jamkhed District, Ahmednagar, Maharashtra, by Inder Jag Mohan, Programme Officer, Field Operations, August I977.

No. I004
Health and Nutrition
Maharashtra.

Kasa Integrated Mother-Child Health Nutrition Project, Dachanu Taluka, District Thane

I. Started: In December 1974.

2. Coverage:

63,000 tribal population in 70 villages (10 of which all control villages).

3. Activities:

This project is a projection of the "Domiciliary Treatment of Protein Calorie Malnutrition" project at Palghar, by the Institute of Child Health, Bombay.

a. Health Services, through home visits - preventive, curative including referral and promotive.

b. Nutritional assessment of under sixes and pregnant and lactating women. Food and vitamin supplements as needed. Local foods are processed as snacks for 2259 (24%) of the children.

c. Immunization: Mass campaigns, plus routine programmes.

d. Surveillance for "at risk" cases: The part-time social workers (PTSWs) identify these cases and refer them to supervisory staff on latter's visits.

e. Family Planning includes sterilizations.

f. Health and Nutrition Education: Using the home-retained growth charts of under-sixes and records of women.

g. Environmental sanitation: Chlorination of drinking water wells involving villagers in activities.

4. Personnel and Training:

Normal PHC staff structure, but some modifications in duties (more supervisory of PTSWs).

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Special Programme Officer (Supervisor).

Part-time social workers (PTSWs - 28) - each covering 2,000 population.

Selected by the communities not highly literate, (literacy rate in area is less than I0%) both male and female (some non-tribal), either residents or from neighbouring villages. These are trained for four weeks initially (both classroom and practical training).

Recently, dais in the area are being tained.

CARE has provided some staff for training, research and supervision.

5. Supervision and Records:

Master time-table for workers; a system of weekly (or more frequent) supervision all along the line.

6. Community and Other Participation:

The PTSWs are from the community and selected by it.

7. Sponsorship/Funds:

GOI, DSW for a year. Later Government of Maharashtra and CARE - Maharashtra are the co-sponsors.

8. Evaluation:

PTSWs' monthly reports include status reports on all aspects; diaries; case study; type of information; tabulations are done at SCs and PHC.

9. Problems:

Government administrative procedures leading to delays, other assignments like FP campaigns, non-posting of staff, dropouts among PTSWs, poor communication netwoek, tribal poverty and resistance, were some of the key problems.

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No. I004
Health and Nutrition
Maharashtra

II. Contact:

Dr P.M. Shah, Hony. Project Director, The Kasa MCHN Project; Prof. of Paediatrics, Institute of Child Health, Grant Medical College, Bombay.

I2. Reference:

Paper presented at the National Symposium , I976.

Note: No information on item IO.

No. I005
Health
Maharashtra

Kasturba Health Society, Sevagram District, Wardha

1. Started: In I964.

2. Coverage:

Wardha C.D. Block

3. Activities:

a. Kasturba Hospital, Sevagram, with 372 beds. The O.P.D. is run by the Department of Social and Preventive Medicine (PSM) in collaboration with those of Medicine and Paediatrics.

b. Mahatma Gandhi Institute of Medical Sciences (started in I969) which is used as a base for delivery of Health Care to the Community.

c. General Nursing and Midwifery Training School (started in I973).

d. Rural centres visited by hospital specialists with weekly clinics at three and fortnightly/monthly clinics at seven others.

e. An ayurvedic OPD functions twice weekly at the hospital (since I975).

f. Yoga and Nature Cure Centre attempts to associate Yoga with modern medicine (since I974).

g. Health Insurance Scheme insures families for Rs. 25/- a year. Village units are also insured. Over I4,000 are insured currently.

h. Need-based, rural-oriented medical training.

i. Research projects including those on improved health delivery systems through school teachers and basic health workers.

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No. I005
Health
Maharashtra

4. Personnel and Training:

Besides the President, there is one Secretary and I7 other members to run the Society.

7. Sponsorship and Funds:

a. The Mahatma Gandhi National Memorial Trust was the fore-runner of the Society.

b. USAID financed the construction and equipment of the new hospital and college building.

c. Interest from its own funds;

d. Donations and Research contributions;

e. Fees from the College and hospital.

II. Contact:

a. Dr. Sushila Nayar, President.

b. Smt. M. Choudhary,
Secretary,
Kasturba Health Society, P.O. Sevagram,
Wardha - 442 I02 (Maharashtra)

I2. Reference:

Annual reports I975-76/ 79-80 of the Society

Note: No information on items 5,6,8,9 and I0.

No. I006
Rural Development
Maharashtra

Maliwada Human Development Project, Aurangabad District.

I. Started: In I975.

2. Coverage: 2,300 population.

3. Activities:

Project aims at human development; Intention is three-fold :

(i) as demonstration village; (ii) as laboratory for refining village development methods; and (iii) as training centre for staffing new village projects.

a. Programmes include: Community health - preventive medicines; medical care; referral services; health education.

b. Demonstration Home : - community kitchen, demestic management; family planning; nutrition education.

c. Community commons - vegetable gardens; animal farm.

d. Community Education - pre-school, infant care, functional education; in-field training.

e. Service Training - technical, rural management, trade skills.

f. Rural Housing - village construction, community industry, community agriculture; irrigation.

g. A cooperative has been set up to manufacture "Sukhdi" - nutritious food packets for distribution in schools of the zilla parishad.

4. Personnel and Training:

a. training school, where VLWs are trained.

b. no full-time faculty, but experts come from abroad and other parts of India and Maharashtra to impart training.

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No. I006
Rural Development
Maharashtra

5. Supervision and Records:

People from other villages where work is to be started are invited to visit and see for themselves the practical operation of the Maliwada Project. A one-day gram sabha meeting is arranged for corporate planning.

6. Community and Other Participation:

The local community has contributed half of the Rs. 20-lakh investment in the Project. Work in a village is started in consultation with the local people with the help of experts from outside.

7. Sponsorship and Funds:

This is a pilot (experimental) project undertaken by the Institute of Cultural Affairs (ICA) with the support of the State Government. This is an effort of cooperation between the ICA and the local community. The basic aim of this project is to improve the quality of rural life and to strengthen the socio-economic condition of the rural poor. This experiment envisages an integrated approach towards rural agriculture, industry, education, health, sanitation etc.

8. Evaluation:

The Project has a system of formation of programme guilds and regular evaluation by the villagers at monthly village meetings.

IO. Outlook:

a. Systematic replication of the Maliwada Project throughout the State.

b. Introduction of new village industries like box-making, rope-making, tailoring, etc.

II. Contact:

Mr Vinod Parekh/Mr W.J. Patterson, Maliwada Human Development Project Aurangabad District, Maharashtra.

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No. I006
Rural Development
Maharashtra

I2. Reference:

WIC, UNICEF Note; "New Partnership in Rural Development" by D. Paul Chowdhry.

Note: No information on item no. 9.

No. 1007
Comprehensive Health
Maharashtra

Rural Health Research Project, North Alibag and Uran Talukas

1. Started: In December 1973 in North Alibagh, only recently in Uran Taluka.

2. Coverage:

In North Alibag Taluka (Mandwa Project) a 30,000 population is covered, and in Uran Taluka 60,000. The population are mostly agriculturists, fisherfolk, and some tribals.

3. Activities:

Initial:

a. Concept of development with community participation promoted by a local community organizer.

b. Medical services by a doctor who also trained VHWs.

c. Baseline survey by Tata Institute of Social Sciences, Bombay.

Outgoing:

a. VHW's home visits (3 hours/day) for minor ailments; check under fives for immunization and nutritional statuses; check for ante-natal cases and for TB and Leprosy symptoms. Also impart health education.

b. ANMs conduct ante-natal clinics and deliveries; give immunizations and refers cases needing further attention to PHC Unit doctor.

c. PHC Unit apart from traditional curative role, the doctor is expected to go out into community, recognize health problems and initiate preventive measures using team. Outpatient clinics are conducted at remote, selected villages.

d. An Uran Taluka, project is taking over the government PHC and re-training its staff as MPWs.

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e. Land reclamation for tribals.

f. Recently, a comprehensive S-E survey conducted as requested by the two new development engineers as a first step to initiate a number of development projects.

4. Personnel and Training:

a. VHWs (part-time, 25-50 years of age; education 2 - 7th standard, but two are illiterate children maintain their records). Orientation is for I0 days, followed by regular in-service training. So far 30 VHWs (I per I,000 population) have been trained in North Alibag.

b, ANMs - Every 5 VHWs were supported by an ANM.

c. A doctor visited each of the 6 subcentres once a week.

5. Supervision and Records:

VHW is given continuous on-th-job supervision. VHWs monthly report is signed by the doctor and a copy sent to the Panchayat.

6. Community and Other Participation:

VHW is chosen by Panchayat and Project personnel together. Part payment of her salary is made by the Panchayat.

7. Sponsorship/Funds:

The Foundation for Research in Community Health, a voluntary organization, sponsors and funds the projects. The Foundation itself is funded by donation from two of the trustees and various charitable organizations in India and abroad, such as the Volkart Foundation, OXFAM and Christian Aid. Government of Maharashtra's PHU and PHC budgets for the areas are also available.

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No. I007
Comprehensive Health
Maharashtra

8. Evaluation:

a. Local health committees were formed to oversee the programmes and assist VHWs in carrying out their duties, especially preventive measures.

b. A general evaluation of both the North Alibag and Uran projects was made by the Foundation for Research in Community Health. It was found that the CHW scheme was not very popular with the PHC.

9. Problems:

a. Villagers take time to gain confidence in VHWs.

b. VHW is more curative - rather than preventive - oriented (training needs reorientation).

c. Her work-pattern is unsystematic because of her previous work-style.

d. ANM has a tendency to look down upon the VHW.

e. Turnover in doctors, their inability to utilize their staff properly, and to delegate jobs to them. They are purely curative-oriented.

f. A tendency for the community to expect all welfare measures to come from the Government.

g. Difference between their perception and the development worker's perception of needs.

IO. Outlook:

Propose to start development programmes including health, sanitation, water supply and land reclamation.

II. Contact:

Dr N.H. Antia, Trustee, The Foundation for Research in Community Health, 84-A, R.G. Thadani Marg, Sea Face Corner, Worli, Bombay 400 -I8.

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No. I007
Comprehensive Health
Maharashtra

I2. Reference:

Paper presented at the National Symposium, I976;
and National Conference on Evaluation of PHC
Programmes, I980.

No. I008
Health
Maharashtra

Sone Guruji Vidya Prabodhini, Khiroda, Talgaon District*

I. Started: In I930

3. Activities:

a. Pre-basic school for children 5 - 7 years of age.

b. Primary basic training college, secondary school, panchayatiraj training centre, boarding house for students from backward classes, arts school and college of education.

c. Dispensary for tribals.

d. Youth Club to promote CD through various activities.

I2. Reference:

John Sommer et al, Rural Development at the Grassroots, The Ford Foundation, New Delhi, October I974.

Note: No information on items 2, 4, 5, 6, 7, 8, 9, I0 and II

(*also called Janata Shikshan Mandal)

No. 1009
Health
Maharashtra

Sirur, Pune District, Maharashtra.

1. Started: In 1939

2. Coverage:

Nearly 37,000 population (19 villages spread over 663 sq. kms.)

3. Activities:

a. Rural Health Services and Training.

b. Provides comprehensive health care services, including referral.

c. Undertakes training courses for medical interns, post-graduate students, B.Sc. Nursing, Nurse Midwives and other special groups.

d. Provides MCH services, nutrition/health education/ family planning, immunization and control of communicable diseases.

e. Undertakes research and evaluation, environmental sanitation and water supply (construction of latrines, soak-pits etc.)

f. Arranges health exhibitions.

11. Contact:

Dr N.S. Deodhar, Joint Director
Health Services
Pune

12. Reference:

WHO, UNICEF Note.

Note: No information on items 4 to 10.

No. IOIO
Rural Development
Maharashtra

Uruli Devachi

I. Started: In 1973.

2. Activities:

a. An integrated Socio-economic and educational programme for landless labourers including training in: (1) human management and family budget; (2) child care; (3) health hygiene and cleanliness; (4) retention of literacy; (5) co-operative activities and village administration; (6) trade union activities; and (7) leadership development.

Craft training and family planning/population education is also given.

Government of Maharashtra will help create some projects in the vicinity under the employment guarantee scheme.

b. A Balwadi which, however, has to be fully crystalised.

4. Personnel and Training:

Government of Maharashtra collaborates on technical aspects such as training on specific subjects.

7. Sponsorship and Funds:

Asian Trade Union College (ATUC); the International Confederation of Free Trade Unions (ICFTU); ILO and UNFPA are co-sponsors.

II. Contacts:

Mr Virendra Kabra, Director, ICFTU, ATUC, B-26 Green Park Extension; Mr Ashok Tupe, Working President Shajeevan Audhyogik Sahakari Society Ltd. Bade Satra Nali, Hadpsar, Poona - 28.

I2. Reference:
WHO, UNICEF.

Note: No information on items 2,5,6,8,9 and IO.

No. IOII
Rural Development
Maharashtra

The Aurangabad Experiment - Co-operative Village Success Involving Community Participation

I. Started: In 1972

2. Coverage:

42 Families (525 adults and children) of landless agricultural workers of a drought-prone Maharashtra village.

3. Activities:

a. Workers learn house construction, brick-making masonry, dairy techniques, electrical wiring and handicrafts as means of supplementing income.

b. Workers attend classes on general topics related to the home, family, nutrition, health, hygiene, child care, etc.

7. Sponsorship and Funds:

This project was organized by the International Confederation of Free Trade Unions (ICFTU), Asian Trade Union College, with funds from a number of organizations, including the ILO.

IO. Outlook:

a. A trade union worker from each village will be engaged for follow-up work.

b. A sum of money will be given to each village group as a subsidy for establishment of a co-operative society.

c. Similar experiments to be started in other over-populated, agrarian Asian Countries with ILO assistance and that of Co-operating funding agencies.

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No. 1011
Rural Development
Maharashtra

12. Reference:

"Community Level Approaches to Health and Nutrition" (As possible ways to reach populations which are difficult to cover by centrally designed and operated government programmes) - by Dr Rajammal P. Devadas, Director, Head and Professor of Nutrition, Sri Avinashilingam Home Science College for Women, Coimbatore.

Note: No information available on items 4,5,6,8,9, and 11.

No. I0I2
Child Care
Maharashtra

Gram Bal Shiksha Kendra, Kosbad Hill

1. Started: In 1945 at Bordi; a coastal village in Thane district; shifted to Kosbad in 1957.

2. Coverage:

Children of different age groups, mainly belonging to the Adivasi tribes of the district.

3. Activities:

a. Orientation Training Programme for teachers.

b. National Adult Education Programme.

c. Community Health Project in 6 Adivasi hamlets.

d. Printing Press programme.

e. Education for children (pre-primary; primary; creches and kishan shalas).

f. "Vikaswadi" Project (composite pattern of school, where a balwadi is joined to a creche on the one hand and to a primary school on the other).

g. Meadow school for Adivasi children, who look after cattle and graze them on the meadows ; night school.

h. Intensive craft training project; carpentry training for drop-outs; production unit for 20 needy women to prepare educational aids and toys.

i. Rural Balsevika training centre for 60 female trainees.

j. Small-scale industries; workshop combined with a primary school to enable tribal children to "earn while they learn".

4. Personnel and Training:

Teacher trainees trained under the rural Balsevika Training Scheme, and the Orientation Training Programme for Teachers.

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No. 1012
Child Care
Maharashtra

6. Community and Other Participation:

Guardians of the children cooperate in the education programmes; women help with the plans to promote literacy, prohibition and family planning.

7. Sponsorship and Funds:

Different schemes are funded by different organizations.

a. NCERT has sanctioned Rs.10,000 for the Orientation Training Programme for teachers.

b. The Social Education Department and the Zilla Parishad help to finance the training course in carpentry for Adivasi boys.

c. Other funding agencies are: G.O.I.; the Government of Maharashtra; the Central Social Welfare Board; Indian Council for Child Welfare; UNICEF; Indian Association for Preschool Education.

d. The Nutan Bal Shikshan Sangh is the parent body of G.B.S.K. which it assists by giving GBSK the benefit of its organizational strength.

8. Evaluation:

A critical appreciation of the 'Vikaswadi Project' at GBSK was undertaken in 1978 by Dr. Chitra Naik, Director of the Indian Institute of Education, Pune, at the instance of UNICEF; it was published under the name: "Growing Up At Kosbad Hill".

9. Problems:

a. Main problems of the Primary School were - small number on the Rolls; attendance irregular; children could not understand and remember what was taught.

b. Teachers could not secure housing accommodation; initially they were not popular with the villagers.

c. The meadow school innovation has languished for want of administrative support and dedicated personnel.

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No. 1012
Child Care
Maharashtra

d. The tribal community's enthusiasm for pre-school education for their children is still not strong enough; many children do not come to the Anganwadis and Balwadis unless the teacher collects them through house-to-house visits.

e. Because of the feeling that cleanliness routines are the teachers' business, many parents do not bother to send the children washed and dressed to school.

f. Many trainees who complete the Balsevika Training Course pay insufficient attention to the sensory training of children.

g. The success of the economic programmes like the press; carpentry workshop, etc. has not come up to expectation.

h. According to the late Tarabai Modak (Founder of GBSK, who first launched the Vikaswadi Project) personal involvement in the Project has not risen strongly enough among the younger members; and the various responsibilities in the Institution are not properly shared by all.

II. Contact:

Smt. Anutai Vagh,
Sanchalika,
Gram Bal Shiksha Kendra,
Vikaswadi Kosbad Hill - 401 703,
Dahanu Taluk, Dt. Thane, Maharashtra.

12. Reference:

Literature published by Gram Bal Shiksha Kendra;
"Growing up at Kosbad Hill".

Note: No information on items 5 and 10.

No. I0I3
Health
Maharashtra

Kailash Trust, Village Ellora, District Aurangabad

I. Started: In 1967.

2. Coverage:

Ellora and three other villages - I,500 families; beneficiaries range from landless labourers to small and medium-sized land-owners and rural artisans. About I5% of the population are Bhils.

3. Activities:

a. Medical relief.

b. Agricultural services comprising distribution of goods quality seeds and fertilizers;

c. Dairy and poultry unit.

d. Adult education.

e. Mahila mandals;

f. Kailash Techno-Development Trust - a socio-economic unit for training youth in remunerative employment such as manufacture of rubber bands; diesel engine parts, etc.

4. Personnel and Training:

a. Village Level Health workers.

b. Medical centre and clinic with a doctor and nurse.

5. Supervision and Records:

Three VHWs visit five to six houses every day and maintain a record for all children under five.

6. Community and Other Participation:

The spirit of self management is encouraged; adequate opportunity is offered to villagers by the Techno Development Trust for them to learn productive skills so that they can make use of their own labour.

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No. 1013
Health
Maharashtra

7. Sponsorship and Funds:

a. Kailash Welfare Trust;

b. A unit for the manufacture of rubber bands is sponsored by the Central Social Welfare Board.

c. For the manufacture of diesel engine parts, machines have been provided by Kirloskar Ltd.

d. Part of the factory's profits are re-invested in the factory for further development.

10. Outlook:

a. The Trust is planning a nutrition programme - "Operation Nutrition" - to cover 450 mothers and children by providing milk and vegetables;

b. Intends to start hand paper and bakery units to provide employment for women.

c. Wants to start a Rural Institute to cater to the needs of villagers especially.

11. Contact:

Ms. Tara Bastikar, Village Ellora
District Aurangabad.
Maharashtra

12. Reference:

"Catalogue of Agencies Reaching Poorest Women in India".

Note: No information on items 8 and 9.

No. I50I
Health
Punjab

Department of Community Medicine, Christian Medical College, Ludhiana.

I. Started: In I972.

2. Coverage:

50,000 in city slums and 60,000 in rural areas, spread over 29 villages.

3. Activities:

a. Considers home visiting important; stresses immunization;

b. Family planning; under 5 clinic and post natal care;

c. Environmental sanitation;

d. health education.

4. Personnel and Training:

Interns, ANMs of College/Government.

5. Supervision and Records:

a. Each family has a family folder; each family is visited once in three months for maternal and child health and other health services. Priority "problem" homes with malnourished children, pregnant mothers with bad obstetric history, are visited every month or more often, if necessary. The CHW is introduced to priority homes, which she visits on alternate days.

b. Before a patient is started on his treatment (especially in T.B. cases), his address is verified, becuuse it is important to follow up the case.

c. Follow-up of children on the 7th and IIth day after immunization to learn of any immediate adverse effect.

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No. 1501
Health
Punjab

6. Community and Other Participation:-

a. The Departments of Medicine, Paediatrics, Ophthalmology, Obstetrics and Gynaecology and Psychiatry are involved, and hold special clinics in both rural and urban centres.

b. Payment of money for medicines is made partially by the patients who, however, cannot pay much.

7. Sponsorship and Funds:

Money for medicines, etc. comes from donors, mostly in Scotland and England, but some from U.S.A. and New Zealand as well. Some money is donated locally by the urban and rural population.

8. Evaluation:

Analyses of ante-natal/delivery services and family planning achievements are conducted annually; and the results tabulated.

9. Problems:

a. Many mothers do not bring children to clinics for immunization saying that the child will lose weight.

b. Identifying T.B. cases is inadequate because even during home visits, many patients, who go out to work all day, are missed; many are ignorant about cure for T.B. requiring two years' treatment.

c. Neo-natal tetanus and puerpural tetanus continue to be a cause of infant and maternal mortality respectively. Some rural women even now refuse to accept the medical services provided by the College.

10. Outlook:

a. Reorganization of Medical Education; attachment of 4 villages in Ludhiana Block with a population of about 10,000 to the Christian Medical College.

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No. I50I
Health
Punjab

b. Introducing original health delivery pattern in the new Block.

c. Expansion of immunization programme.

II. Contact:

Dr. C.M. Harbans Dhillon, Professor and Project Director;
Prof. B. Houre, O. and G. Department.

I2. Reference:

VHAI ; College Annual Report.

No. I60I
Child Care
Rajasthan

Rajasthan Adimjati Sevak Sangh (RASS), Jaipur

I. Started: In I957.

2. Coverage:

Tribal people in rural areas of Rajasthan.

3. Activities:

a. Runs hostels for Advasi children (4 to I4 years) at 20 places.

b. Runs residential schools for Advasi children at Rikhabdeo (Udaipur) and Shahabad (Kota) where about 500 students are living and being educated up to primary and secondary school levels.

c. Runs 50 functional literacy centres.

d. It has Adimjati Rehabilitation Centres at 9 places.

e. Seven homes for destitute children, four of them at Udaipur.

f. Integrated Development Programme Centres for woollen, cotton and khadi articles in 4 places, where both production and sale of khadi and silk are undertaken.

g. Helps tribal youths to get admitted to technical institutions.

h. Helps to rehabilitate tribals by arranging for allotment of land to them.

i. A tribal study centre was established at Udaipur to study all aspects of tribal life.

j. Established "Palnaghars" (Creches) for the very young children of tribal parents who are working in the stone quarries of Kota District.

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No. I60I
Child Care
Rajasthan

k. It has built simple shelters for destitute tribal children in remote rural areas, using local materials.

4. Personnel and Training:

The Sangh has about 60 full-time and about I00 part-time workers on its staff.

6. Community and Other Participation:

Self-help from the tribals themselves in encouraged and HEART (Housing, Education, Action, Research, Training), Baroda, provides technical assistance for the construction of hostels.

7. Sponsorship and Funds:

The Sangh gets its resources through public donations and funds from the Central and State Governments on a project basis, and the Departments of Adult Education and Literacy, Social Welfare, and the Khadi and Village Industries Commission, Bombay. 90% Central Government grants are given for some projects.

9. Problems:

Raising even I0% of its annual expenditure through its own resources, is a major problem for the Sangh.

II. Contact:

Shri Banwari Lal Gaur, Secretary, Rajasthan Adimjati Sevak Sangh (RASS), Naval Nivas, Ashok Nagar, Subhash Marg, Jaipur 302001, Rajasthan.

I2. Reference:

"Reports on Voluntary Agencies in India"
Prof. M.B. Achwal, Director, HEART, Baroda.

Note: No information on items 5, 8 and I0.

No. I602
Community Development
Rajasthan

The Social Work and Research Centre (SWRC), P.O. Tilonia Kisangarh, Dist. Ajmer, Rajasthan.

I. Started: In February I972.

2. Coverage:

a. This is a Rural Integrated Community Development covering rural areas of Rajasthan, Punjab and Haryana.

b. In its Community Health Programe , it covers 25 villages of about 20,000 people.

3. Activities:

a. Ground Water Exploration (28 villages in Haryana)

b. Agriculture.

c. Health.

d. Education.

e. Raising output of rural areas by establishing communication links between specialists - like geologists, social workers, teachers, engineers and doctors and farmers.

f. It has prepared a detailed survey of Silora Block (which includes II0 villages under the Agricultural Reliance Corporation - ARC) for development of minor irrigation and providing electric pump sets.

g. It carried out a survey of 5I villages for the Rural Electrification Corporation - REC.

h. Recharging of open wells by perforating percolation tank beds in strategic places.

i. Distributed seeds and fertilizers to farmers in I7 villages around Tilonia and 500 samplings of fruit and shady trees to families in 3 villages.

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No. I602
Community Development
Rajasthan

J. A farmers' training camp for the rabi season was organized.

k. In February I973, it established a dispensary at Tilonia and has up to now treated about 70,000 patients from 60 villages around Tilonia.

l. Since I975, it has been working as a Community Health Programme, laying emphasis on food and nutrition, water for irrigation and drinking, preventive and curative health.

m. Vocational training for women and reviving of traditional crafts like moda-making, leather work, cloth block printing, etc.

n. It has undertaken a small Low Cost Housing programme in Khori (Rewari Tehsil) in Haryana.

o. Also an environmental improvement programme and experimental ANP programme in Haryana.

p. It runs the Tyabji Clipper Windmill at Tilonia as a demonstration wind mill for draining water.

q. Gives training in the operation of agricultural implements, ghani, weaving units, etc.

r. 3 Primary schools in Tilonia, Buharu and Phaloda villages have been taken over by SWRC from the Development Department of Rajasthan Government for three years to run the experimental Primary school educational research programme.

s. Conducts the working of the UNICEF Film Strip Kit, which is an easy do-it-yourself kit enabling any illiterate villagers to make a film strip from start to finish. All the ten VLHWs have been trained to use it and they have been making strips on sanitation, health, village life, etc.

t. The Balvadi in Tilonia was started in I974. The children are served a mid-day meal as part of the nutrition programme.

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No. 1602
Community Development
Rajasthan

4. Personnel and Training:

a. Has 10 General Body members including a Director and Joint Director. Its Governing Body consists of 5 members and 23 other specialists like sociologists, economists, doctors, nurses, geologists and geophysicists.

b. VLHWs, chosen by villagers are given training in its centre at Tilonia.

c. Local 'dais' are selected and trained.

d. In-service training programme for teachers is given.

e. Training to health education and school health programme was organised with the help of the Medical Department of SWRC: and another training programme for Maths was organized in collaboration with the centre for Educational Technology, Delhi.

f. The SWRC has a staff of 1 Doctor, 4 ANMs, 1 Compounder on the Medical side; a Medical Social Worker and 1 Para-Medical Worker on the health side.

5. Supervision and Records:

a. Teachers are supervised in their day-to-day work by the Project-In-Charge and the Field Supervisor.

b. Weekly meetings of teachers every Saturday - work of the previous week is reviewed and plans for subsequent week are made.

c. Periodic visits are made tothe Centre, where supervisors help teachers to build a link between the community and Learning Centres.

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d. A medical team from SWRC visit each village once in 15 days. The VLHW collects the patients in one place and the doctor examines them. To keep a regular check on the VLHW, there are weekly meetings at the SWRC, where patient and drug registers, receipt books and general work are checked, and evaluated. This is often followed up by surprise visits to the different villages either by the Community Health Worker or the Medical Social Worker.

6. Community and Other Participation:

A medical camp was conducted by the Department of Social Work and Welfare in collaboration with Dey's Medical Store, Jaipur, and the Kohinoor Lodge, Jaipur. A group of 4 doctors, an eye specialist, an ENT specialist and 2 general practitioners treated the patients, assisted by the doctor of the centre in Tilonia. Volunteers from the village community also helped. The Director of the Co-ordinating Agency for Health Planning examined orthopaedic cases from the village and made suggestions regarding rural health programme in general.

7. Sponsorship and Funds:

The SWRC receives project grants from the Central and State Governments, UNICEF, OXFAM and also generates its own funds. For its balwadi at Tilonia, the Centre has received a grant of Rs.2,000/- from the Social Welfare Board.

8. Evaluation:

a. Annual assessment of the students of the Learning Centres was done by the Regional College of Education, Ajmer, and the SWRC. The evaluation process was developed by the Department of Education of the Regional College.

b. The Community Health Programme was evaluated in August 1976 by a team of experts sent by the Family Planning Foundation.

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No. 1602
Community Development
Rajasthan

9. Problems:

In the primary education programme started in 1975:

a. Poor response in primary school.

b. Drop-out rate very high by the end of the second year.

c. School timings unsuitable because many school children work on the farm and graze cattle.

d. Apathetic attitude of teachers because they are outsiders; they are always under threat of transfer; there is a lack of teaching aids and physical facilities.

e. The school is segregated from the community.

f. Initial resistance to the take-over of schools from the Panchayat Samiti by SWRC, because the Panchayat alone was not consulted, but opinions of parents also were sought.

g. In its health programme, prejudices and superstitious beliefs were at first difficult to break down.

IO. Outlook:

a. A whole block of 51 villages in Rajasthan is to be electrified.

b. To conduct a detailed survey of Panchayat Samiti Jawaja under the Drought Prone Area Programme (DPAP); - to collect data on the drainage pattern, potential for soil conservation programmes and construction of tanks.

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c. Proposes to start a work centre at Tilonia with the Education Ministry's help, to encourage women to make handicraft items on a daily-wage basis to be sold through the SWRC.

d. SWRC has opened 2 more sub-centres at Khori in Mohindergarh Dt. in Haryana and in Bhatinda District in Punjab, where similar Community Health Programmes as in Rajasthan are to be started.

II. Contact:

Shri Sanjeet Roy, Director, SWRC, P.O. : Tilonia - 305812, Madanganj, Dt. Ajmer, Rajasthan State.

12. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda; and other reports on the various projects published by SWRC.

No. 1603
Education , Health
Rajasthan

Seva Mandir, Udaipur

1. Started: In 1966.

2. Coverage:

Three Panchayat Samitis cover needy men and women (many of whom are Adivasis) in rural and urban areas of Udaipur and surrounding villages.

3. Activities:

a. Adult Education - functional literacy centres; rural mobile library; non-formal education; 50 of the adult education centres are for women; publications for neo-literates.

b. Mobile Health Unit.

c. Water development.

d. Harijan welfare.

e. Farmers' Functional Literacy Project.

f. Rural development project.

g. "Peer Group Project - Action Research Project" - consisting of the formation of groups of "Peers", men belonging to the same age group, for the purpose of planning and implementing development programmes in their respective villages.

h. 100 Household Industries Training Project - to provide assistance, know-how, finance, training and marketing facilities for at least one member in each of a 100 selected households; to set up household industries in tailoring, knitting, wooden toy-making, cardboard box making etc.

4. Personnel and Training:

a. Interdisciplinary team of specialists (agriculture, cooperative organizer, rural engineer, etc.)

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b. Personnel trained under the "Peer Group Project".

5. Supervision and Records:

Regular recording, review and reporting of on-going programmes are undertaken.

6. Community and Other Participation:

The Community and Government agencies provide part of the resources for the implementation of programmes.

7. Sponsorship and Funds:

a. Some projects are "plugged in" to the development schemes of the Drought Prone Area Programmes (DPAP) of GOI.

b. Farmers are given financial and technical assistance by Seva Mandir in collaboration with Land Development Bank; Small Farmers' Development Agency; and the Government Extension Agency.

8. Evaluation:

Careful evaluation involving experts and senior project officers, is done periodically.

9. Problems:

Has not been able to involve many women as participants in various rural activities, or as leaders; this is because of the orthodoxy prevalent in Rajasthan; and also because most field workers are men.

IO. Outlook:

a. Establishment of a women's Development Unit to work for greater involvement of women in Seva Mandir's development efforts.

b. Identification and training of VHWs and arranging for the training of village 'dais'.

No. 1603
Education, Health
Rajasthan

c. Rural industries workers to identify cottage and village industries, in which women can be employed.

II. Contact:

Smt. Ginny Shrivastava, Director,
Women's Development Unit,
Seva Mandir, Udaipur, Rajasthan.

12. Reference:

"Catalogue of Agencies Reaching Poorest Women in India";
"New Partnership in Rural Development" by D. Paul Chowdhry;

No. 1701
Health
Tamil Nadu

Deenabandu Medical Mission, R.K. Pet, Chinglepet District

1. Started: In 1955.

2. Coverage:

20,000 - especially from poorest 40 per cent.

3. Activities:

a. Community Health Programme.

b. Leprosy Control.

c. Family Planning.

d. Primary Care (MCH) .

e. Orphanage.

f. Agricultural Services.

g. Cooperative Farming.

h. Printing Press.

i. Carpentry Shop.

j. Auto Shop.

4. Personnel and Training:

Village volunteers and mid-wives; VHWs.

5. Supervision and Records:

Each VHW has a small register with one page for each family. She visits each of 200 families under her supervision frequently to know the health condition of each member of the family.

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No. 1701
Health
Tamil Nadu

6. Community and Other Participation:

a. Villagers pay for the medicines they use.

b. Consultants for the medical aspect of the Project are drawn from the Christian Medical College, Vellore, and the Tamil Nadu Christian Council.

c. Cooperation with Government and other Agencies.

7. Sponsorship and Funds:

Bread for the World has given Rs. 400,000 as fixed deposit, from which farmers take loans for irrigation and cooperatives. Finances are also being met by GOI, State Government, N.C.C. Committee for Relief and Gift Supplies; CORAGS: World Neighbour Inc.; Division of World Ministries; United Church of Christ, U.S.A., Reformed Church in America; S.S. Central Park Church; Protestant Evangelical Church of Switzerland, HEKS; Kindernolhilfe, Children's Aid Association of West Germany.

8. Evaluation:

Evaluation was carried out once at the end of three years, and again at the end of five years. The following indicators have base-line data for comparison:

Birth rate; infant mortality and maternal mortality rate; incidence and prevalence rates of T.B. , Leprosy, Kwashiorkar; agricultural output(production); per capita and disposable income.

An evaluation of two specific facets of the programme- treatment and rehabilitation work for leprosy patients; and family planning and Rural Hospital Scheme - has also been done at the request of the HEKS Office at Bangalore.

9. Problems:

The population chosen for family planning work was unduly large and it was feared that it would dilute the intensity of services.

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No. 1701
Health
Tamil Nadu

11. Contact:

Dr. Prem Chandra John MPH., Deenabandhu Medical Mission, Integrated Community Health Project, R.K. Pet, Chinglepet, N. Arcot District, Tamil Nadu 631 303.

12. Reference:

VHAI

Note: No Information on item 10.

No. 1702
Health and Rural Dev.
Tamil Nadu

Kottar Social Service Society, Nagercoil

1. Started: in 1956.

2. Coverage:

126 villages in Kanyakumari district - target population of 50,000 (50 per cent of district population). Not all villages have all activities.

3. Activities:

1. Health (since 1971)

a. Drugs and medicaments dispensation.

b. Clinic for health education, ante-natal check-up, first aid and minor ailments care.

c. Comprehensive health education.

d. Home visits.

e. Home gardening.

f. Sanitation.

g. Nursery schools.

h. Common fund for providing environmental sanitation in village (25 paise scheme) and

i. Nutrition supplement.

2. Economic activities such as:

Palmyra Tappers Co-operative (1954) - to improve working and living conditions of palmyra climbers.

Nylon Net Manufacturing Centre (1967) - to provide new fishing nets and prevent exploitation of the labour.

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No. 1702
Health and Rural Dev.
Tamil Nadu

Channel Irrigation Project (1968) - organization of local communities to dig feeder canals and terrace the land of marginal farmers.

Young Fisherman's Sangams (1973) - organization by potters into a co-operative.

4. Personnel and Training (Health Scheme)

a.	Community Organizers	12	- 8 of them trained at ISI, Bangalore.
b.	Registered nurse and midwife	16	
c.	ANMs	2	
d.	Pharmacist	6	- 3 months' intensive training in community health, community development, midwifery and home management.
e.	Health Guide	16	- General school-leaving certificate; 1 year's intensive training in the above area plus mother and child care.
f.	Health Guide	16	- 5 years experience in hospital work; training is then for 4 months.
g.	Health Educator	42	- Graduates; 3 months intensive training in community health and development; home gardening.
h.	Health Worker	64	- School-leaving certificate; 5 months intensive training in the above area after one year as voluntary extension worker.

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i. Home Science diploma holder 6

j. Community Development and child care diploma holder 4

k. Inservice Trainees 10

l. Stipendary inservice trainee 17

m. Trainees 199

5. Supervision and Records:

a. Local volunteers (unemployed girls who have completed Secondary Education) make an initial survey of under-fives and pregnant mothers. Later, meetings are held to stress the necessity of local involvement of starting health clinics;

b. Special teams, each comprising a community health guide, one or two health workers and one health educator, have been constituted. The composition of these teams are constantly reviewed. Once a fortnight, each team visits a village and meets mothers and children registered in the schemes; every hour groups of 20 - 25 mothers talk to the health worker on nutrition or health;

c. Home visits by health workers to review the health talks given earlier to groups;

d. Health educators under training are sent to different villages to stay with the people for a month at a time to discover weaning practices, food habits, etc.

6. Community and Other Participation:

KSSS has followed the principle of a single demonstration of any idea, followed by responses to requests for assistance/intervention by communities. In the health project, in addition, the project staff are from nearby communities. The 25 paise lottery scheme involves contributions, decision making and assignment of priorities by the community.

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No. 1702
Health and Rural Dev.
Tamil Nadu

7. Sponsorship and Funds:

KSSS is a creation of the district Roman Catholic Diocese. Funds are received from international/bilateral sources including CRS foods.

8. Evaluation:

A team of social scientists evaluated the society some years ago. A numer of modifications have resulted from this evaluation.

9. Problems:

a. Retention of staff, especially since the main objects of recruitment and training are to prepare young girls for life. After marriage, they no longer work for the project.

b. Supplies.

c. Supervision and training - need for government's formal recognition.

d. Transport costs.

e. Financial problem.

10. Outlook:

From peripatetic health teams, the move is towards a health co-operative.

11. Contact:

Fr. James and Sister Lieve of KSSS, Bishop's House, P.B. No. 17, Nagercoil, Kanyakumari, Tamil Nadu 629 801.

12. Reference:

Annual Reports of KSSS; WHO/SEARO and UNICEF/SCARO.

No. 1703
Health
Tamil Nadu

Mini Health Centres Project, Voluntary Health Services Medical Centre, Madras.

1. Started: In 1974.

2. Coverage:

1,000 families (5,000 population), roughly, in the St. Thomas Mount C.D. block of Chingleput district.

3. Activities:

a. Preventive and promotive care combined with curative care for serious illnesses.

b. Enrolment of the family at the medical centre.

c. Tri-weekly clinics at the centre by the MO and supporting staff.

d. Establishment of health posts that are at the periphery of the mini-health centre's area to serve 500-1000 population through lay first-aiders.

e. Periodic visits by health team of the mini-health centre and examination/treatment of children at risk, women in need of ante-natal care and eligible couples.

f. Maintenance of complete record on health status for each family member.

4. Personnel and Training:

a. A part-time medical graduate for 3 hours/day.

b. An ANM at each health post.

c. At the mini-health centre, helping the doctor and supervising the ANMs are para-medicals- PHN, LHV, a nutrition worker, a laboratory technician, and health administration assistant.

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No. 1703
Health
Tamil Nadu

d. Lay first aider at health post- 4 weeks' training and then continuous in-service training and supervision. She is paid Rs. 50/- a month plus Rs. 2.50 on health team's visit days. She must be a permanent resident of the village and have a basic education.

e. Two additional helpers on visit days.

6. Community and Other Participation:

A project committee is formed with representatives of government and the VHS (Parent body for the project). A token contribution of Rs. 0.50 is levied on each family in the scheme; Rs.1/- for the next slab (upto Rs. 200/-) and 0.5% of the income of the higher slabs. Use of community workers and helpers are also part of the scheme.

7. Sponsorship and Funds:

The Voluntary Health Services is the sponsor along with the state government and the local communities.

9. Problems:

a. Difficulty in obtaining the community contribution continuosly and regularly due to other health care being available for specific groups.

b. Quality of services are affected by the low motivation of the government para-medicals, and the lack of security among the lay workers.

10. Outlook:

It is suggested that a mini-centre cover 5,000 pop., and the help of voluntary agencies be taken. These should be run by their own staff. The medical officer of the PHC should be not a raw graduate but a more senior doctor.

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No. 1703
Health
Tamil Nadu

11. Contact:

Dr. K.S. Sanjivi, Prof. Emeritus in Medicine, Madras Medical College, Madras.

12. Reference:

Paper presented at the National Symposium, 1976; Annual Report 1975, and 1974 of the Voluntary Health Services; SIO, UNICEF, note.

Note: No information on items 5 and 8.

No. 1704
Health
Tamil Nadu

Nutrition Rehabilitation Centre and Village Child Care Centres
Nutrition Rehabilitation Centre, Govt. Erskine Hospital, Madurai

1. Started: In 1972.

2. Coverage:

Overall coverage is 100+46 villages in 2 blocks. 6,458 children are covered. Number of centres: 10 active; 39 completed (VHW function i. only 6 of them).

3. Activities:

a. Preliminary nutrition and Health survey.

b. Demonstration feeding of severely malnourished/ vitamin A deficient 2,000 children.

c. Treatment of common diseases (whole project pop.)

d. Immunization:

1) oral polio vaccine
2) triple antigen (for those below 4 years); and
3) dual antigen.

e. Nutrition and health education for mothers.

f. Pre-natal and ante-natal care.

g. Family planning services.

h. Production of nutritious foods.

4. Personnel and Training:

a. 23 village health workers - local middle-aged women - 2 weeks pre-service; and 2 days/ month in service.

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No. 1704
Health
Tamil Nadu

b. Supervisors: 2 Paediatricians and team.

c. Medical interns and PG students - 10 days as part of P and S medicine course.

d. Recently - staff of obstetrics and gynaecology department.

e. Experts from Ag. College and Research Institute.

f. One (1) Honorary director.

g. Two (2) Public health nurses.

h. One (1) Nutritionist (for 100 village scheme).

i. One (1) Clerk/cum-typist

j. Two (2) Drivers.

k. Nineteen (19) Cooks.

5. Supervision/Records:

Personnel b,g,h, routinely supervise relevant activities/ personnel.

6. Community and Other Participation:

The VHW is recommended by the villagers. Medicines are supplied at cost price and revolving fund is thus created.

7. Sponsorship/Funds:

Department of Social Welfare, Tamil Nadu and partially under 46 village scheme, the Associated Country Women of the World/Royal Commonwealth Society for the Blind, London.

8. Evaluation:

Analysis is made on pre and post statuses, reduction in higher grade malnutrition, xerophthalma, common illness prevalance was noted. Long term effects have been studied. Retention of improved grades was high.

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No. 1704
Health
Tamil Nadu

9. Problems:

a. Lack of availability of fresh vegetables.

b. Fear of children being made sterile by eating what was thought to be some mixtures in the supplementary nutrition.

c. One block has poor communications.

d. Lack of purchasing power, especially due to the drought leading to inability to use even the cheap diets advised.

e. Low wages leading to large turnover.

f. Paucity of funds for needed drugs.

g. Inadequate staff for follow-up.

10. Outlook:

To have under fives register in all villages; complete birth registration; recording of health/nutritional statuses to identify 'at risk' children, supervisors to modify plans to get better and lasting results.

11. Contact:

Dr. A. Venkataswamy; Dr K.A. Krishnamurthy (Prof. of Paediatrics).

12. Reference:

G. Venkataswamy "Child Care Centres in 100 and 46 villages", paper presented at the National Symposium on "Alternative Approaches in Health Care Delivery Systems".

No. 1705
Health
Tamil Nadu

Role of Sri Avinashilingam Home Science College in Nutrition and Health Programme - Coimbatore, Tamil Nadu.

2. Coverage:

Local community.

3. Activities:

a. The college has integrated teaching, research and extension in the many programmes offered.

b. Action-research projects linked with the on-going programmes in nutrition, health nutrition education, child care, housing management, pre-school education, extension, family planning and consumer behaviour have been taken up.

c. Special projects in the rural areas as part of the research schemes have been undertaken.

d. Education in diet, nutrition and health surveys is imparted through modern and relevant folk methods such as dramatization, puppet shows, etc.

e. Screening movies, projecting slides and using flannelgraphs along with home visits are also included.

f. The college undertook a study of a project before and after the implementation and operation of an ANP under the guidance of the college for 3 years. 150 rural home-makers in a post-ANP block and 150 in a non-ANP block constituted the sample for the study. (The studies showed that ANP has great scope in improving the nutritional status of the vulnerable groups in the rural community).

g. Two on-going current projects of the College are: the Integration of Nutrition Education in 600 primary schools in Coimbatore Dt., and the Extension Training Development Project in 5 villages.

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h. At the State Government's request, the College undertook to give help and support to the organisers of the Special Nutrition Programme (SNP) in Coimbatore city to serve as a link between the SNP centre and the community.

4. Personnel and Training:

Research Workers approach individual families in selected rural communities through their local leaders and the alumni of the college; they live in the village for long periods and participate in village activities to establish rapport and become accepted. Then they conduct diet, nutrition and health surveys covering different age groups and locate health and nutrition problems.

5. Supervision and Records:

Every SNP Centre has a small Advisory Committee of local to supervise its functioning and create awareness among the community. Individual members of the committee visit the centres occasionally at the time of bread distribution. The committee also meets frequently to ensure efficient functioning of the Centres.

6. Community and Other Participation:

a. Parents, teachers and school children have been motivated to extend their full co-operation.

b. Hahalir Manrams (Women's Clubs) have become instruments for tapping and developing leadership and for urging families to use desirable methods of feeding children and families.

c. Local leaders and the school headmaster have helped to construct school kitchens in several villages: Local leaders also help to bridge the links between the SNP centres and the beneficiaries served by them.

d. Some parents also co-operate in preparing a variety of nutritious food stuffs and donating some items themselves.

No. 1705
Health
Tamil Nadu

e. Rural people contribute money, materials and physical labour.

f. Community participation is evident in helping the organizers to distribute food, supervising the children forming queues for orderly distribution, preparing attendance cards, etc.

7. Sponsorship and Funds:

a. Special projects in the rural areas are part of the Research Schemes sponsored by the Government of Tamil Nadu, the Food and Nutrition Board of the Ministry of Agriculture and Irrigation, Government of India, the ICMR, ICAR; NCERT; and CARE.

b. The SNP is 100% centrally sponsored. Most of the SNP centres are managed by the voluntary institutions.

11. Contact:

Dr Rajammal P. Devadas, Director, Head and Professors of Nutrition, Sri Avinashilingam Home Science College for Women, Coimbatore 641 011, Tamil Nadu.

12. Reference:

"Community Level Approaches to Health and Nutrition" (As possible ways to reach populations which are difficult to cover by centrally designed and operated Government programmes) - by Dr Rajammal P. Devdas.

Note: No information on items 1, 8, 9, and 10.

No. 1706
Nutrition
Tamil Nadu

Slum Clearance Nutrition Project of Tamil Nadu

1. Started: In 1974.

2. Coverage:

24 Slum clearance areas (initially 12, and later 12 more) with 6,323 families in the earlier phase and 6,500 in the later. Each of the first 12 areas covered a total population of 32,558.

3. Activities:

a. Use of the most effective media to create an awareness of, and interest in the need for sound nutrition and sanitation.

b. Home visits, group discussions and lectures; demonstrations by extension workers to strengthen the induced awareness and motivation.

c. Expansion of existing activities centred around nutrition education and relevant aspects of hygiene and health to include immunization and deworming.

d. Imparting of nutritional and health messages through film shows, magic lantern shows, posters, booklets and pamphlets.

e. Starting of "Day-care" centres, and sewing projects.

7. Sponsorship and Funds:

The Project was sponsored by the Social Welfare Department of the Tamil Nadu Government and CARE with close collaboration from the "New Residents' Welfare Trust" of Madras.

10. Outlook:

a. To produce and promote the widespread use of low-cost locally-made infant weaning food.

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No. 1706
Nutrition
Tamil Nadu

b. To extend mass de-worming and immunizations to the entire target population.

c. To create employment opportunities for a maximum number of women through financing cottage-craft and handicraft units.

d. To improve the working efficiency of the already started Day-care Centres through short-term training, orientation programmes for the 'balasevikas'.

e. Other training projects in crafts (besides sewing) to be started.

12. Reference:

"Community Level Approaches to Health and Nutrition" (As possible ways to reach populations which are difficult to cover by centrally designed and operated government programmes) - by Dr Rajammal P. Devadas, Director, Head and Professor of Nutrition, Sri Avinashilingam Home Science College for Women, Coimbatore 641 011, Tamil Nadu.

Note: No information on items 4, 5, 6, 8, 9 and 11.

No. 1707
Education
Tamil Nadu

Indian Association for Pre-School Education, Coimbatore

1. Started: In 1964

2. Coverage:

National level professional organization serving needs of those working in the areas of pre-school education, child development and welfare of the pre-school child. It has branches in many States.

3. Activities:

a. Promotes the study of the needs and problems of the young child.

b. Establishes and assists institutions for the development of the young child.

c. Collaborates with agencies which are concerned with the young child; promotes close collaboration between the home and the school in the interests of the young child.

d. Acts as a clearing house of information about the young child.

e. Organizes workshops, conferences, etc. on topics relating to the young child.

f. A quarterly journal "Balak" is published in English, Hindi, and Gujarati; the Association has also brought out useful publications for the use of those working for the child.

4. Personnel and Training:

a. Elected executive committee looks after the administration and management of the Association.

b. The executive committee consists of a President, Vice-President, Treasurer, Secretary and Joint Secretaries.

c. Sub-committees are constituted when necessary.

d. The Secretary looks after the implementation of the programmes.

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No. 1707
Education
Tamil Nadu

7. Sponsorship and Funds:

Membership fees, donations and grants-in-aid from State and Central Governments for specified purposes form the funds of the Association.

10. Outlook:

It is proposed to publish "Balak" in other regional languages.

11. Contact:

Ms. S.S. Jayalakshmi, Secretary (IAPE)
Vidya Vikasini,
64, Ponnarangam Road,
R.S. Puram,
Coimbatore - 641 002

12. Reference:

Information supplied by Secretary, IAPE.

Note: No information on items 5,6,8, and 9.

No. 1901
Health
Uttar Pradesh

Community Health Project, Lalitpur, Jhansi District.

1. Started: In March 1976.

2. Coverage:

1 village.

3. Activities:

a. A weekly consultation clinic inc. health talk and demonstration, MCH and other referrals by VHWs at village.

b. VHW will concentrate on MCH prevention and deliveries.

c. Village Health Committee decides on village health.

d. Supply of medicines at cost price.

4. Personnel: Training:

Doctor	1)	
Midwife/lab. technician	1)	Hospital based.
Paramedical worker	1)	
VHWs (F)	2	Weekly at village over 40 weeks plus training through the weekly clinic (Community based)
VHW (M)	1	

Volunteers when needed -

5. Supervision and Records:

Supervision is at weekly clinic by head office staff (Delhi) periodically. Medicine rates given to village panchayat tocheck rates charged by VHW.

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No. 1901
Health
Uttar Pradesh

6. Community and Other Participation:

Choice of village is dependent on co-operation of panchayats; agreement to pay VHW's salary at rates hospitals are party to; establishment of village health committee; building availability for clinic; villagers pay for their medicine. Government DMO is consulted in choice of villages that are to be taken in the twilight areas of the PHC/SCs.

7. Sponsorship/Funds:

Harriet Benson Memorial Hospital (under the Emmanuel Hospital Assn. of India, Delhi). Anticipate funding from agencies abroad for 3-5 years. Community contributions as above. Government contributions for vaccines/iron folic acid and vitamin A; some FP teaching materials are dependent on government stock position.

8. Evaluation:

Planned: A review of VHW training after 1 year, impact in child and maternal mortality and morbidity; diagnosis and treatment of major diseases; changes in health knowledge.

9. Problems:

Social distances based on caste are very rigid leading to need to train VHWs of high and low caste to attend in these caste groups; villagers' suspicion of medical aid because of past exploitations; taboos for pregnant women extending to medicines.

10. Outlook:

Cover 30,000 population in 15/20 villages over a five year period; training at least 1 VHW per village on the basis of 1/1000 population. To make programme fully self-supporting.

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No. 1901
Health
Uttar Pradesh

11. Contact:

Dr N.K. Bachan.

12. Reference:

"Community Health Project", paper presented at the National Symposium on "Alternative Approaches in Health Care Delivery Systems"; Hyderabad, October, 1976, ICMR.

No. 1902
Community Development
Uttar Pradesh

All-India Seva Samiti (AISS), Allahabad, U.P.

1. Started: In 1914

2. Coverage:

Is an All-India movement for social service and community development.

3. Activities:

a. Even in the pre-independence era, this organization used to undertake social work such as organizing relief work in famine-hit areas; starting the "Boy Scout Movement", which has now developed into the internationally recognised "Bharat Scouts and Guides", granting financial, educational and social assistance to the Naik girls (some hill tribes of Almora, Nainital and Garhwal); succeeded in getting the 'Naik Girls' Protection Act' passed in 1929.

b. It now runs the Vidya Mandir Inter College, a hospital and a Gymnasium at Allahabad.

c. A "Mushran" dispensary is being run at Telia Baug, Varanasi. 36,486 patients were treated here in 1973-74.

d. Organises annual Eye donation/Eye Care camps at Allahabad where operations are successfully performed.

e. Runs information centres at Allahabad, Varanasi, Hardwar Railway Stations where pilgrims and others receive information and guidance.

f. It runs a night school at Rajapur for about 40 students.

g. It has started 2 libraries and runs a gymnasium (or Akhada) where various aids for physical exercises are available.

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No. 1902
Community Development
Uttar Pradesh

4. Personnel and Training:

There are 38 general members, including a President 12 Vice-Presidents, 1 General Secretary, 10 Secretaries and 15 Committee Members. There is also a Chartered Accountant. The Finance Committee has 15 Members, the Hospital Managing Committee has 16, and the Akhada Committee has 9.

5. Supervision and Records:

7 staff members look after the administration of various branches. Also, a full-time Organizing Secretary co-ordinates activities and looks after the Head Office and its branches.

6. Community and Other Participation:

From time to time, in its organization of "Melas" in Hardwar, Allahabad, etc., it collaborates with The Servants of India Society, and the Marwari Sahayak Samiti of Calcutta.

7. Sponsorship and Funds:

The AISS receives grants from the Central and State Governments, municipalities, donors and well-wishers.

11. Contact:

Shri Shri Ram Bharatya, Organizing Secretary, All-India Seva Samiti, Allahabad - 211 003 (U.P.)

12. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda.

Note: No information on items 8 to 10.

No. 1903
Community Development
Uttar Pradesh

Agrindus Institute, Govindpur, Mirzapur District.

1. Started: In July 1968.

2. Coverage:

About 300 villages in four community development blocks, scattered over a forest area of nearly 1500 sq. miles.

3. Activities:

a. Health education and service

b. Family planning education and service

c. Medical care.

d. Rural health problems

e. Training of 100 "Swasthya Mitras" for 100 villages in short duration training camps. (A swasthya mitra is a person with knowledge about healthy living habits, planning and treatment of minor ailments)

f. Agricultural demonstration farm

g. Functional literacy; adult literacy

h. Education of children

4. Personnel and Training:

In the chain of village health service, there are four links:

a. Swasthya Mitra - one to two for every village.

b. "Gramin" doctor - one for a group of about 10 villages; he is the link between the swasthya mitra and the doctor.

c. hospital centre - a doctor with his assistants to take care of the serious and complicated cases; one hospital centre for a group of 40 to 50 villages.

d. Medical institutions with specialized services - one for 200 to 300 villages.

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No. 1903
Community Development
Uttar Pradesh

e. For the PHC facility, local people are trained.

5. Supervision and Records:

Village health personnel are guided and supervised by the Centre.

6. Community and Other Participation:

Cost of treatment is borne mainly by the patients themselves. The deficit, if any, is met through the village health fund. Community leaders take keen interest in the village development and in promoting community programmes. The Banwasi Ashram workers and villagers are working together for economic development and social change.

7. Sponsorship and Funds:

The Institute was established by the Banwasi Sewa Ashram: and financial assistance was provided by "War on Want" of England. "Gramkosh" or revolving fund has been set up in each village.

8. Evaluation:

An evaluation of the comprehensive rural development approach, including the health services of the Banwasi Sewa Ashram was undertaken by the Agricultural Finance Corporation, Bombay.

9. Problems:

a. Backwardness of the area - so, physical hardships.

b. Difficulty in finding trained personnel to work.

c. Lack of understanding about the local culture and social compulsions of the tribals.

d. The health problems were related to unclean personal habits; lack of awareness about community health; low purchasing power etc.

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No. 1903
Community Development
Uttar Pradesh

11. Contact:

Ragini Prem, Agrindus Health Project,
Banwasi Sewa Ashram,
Govindpur (via Turra)
Mirzapur District (U.P.)

12. Reference:

Paper presented at the National Conference of Evaluation of PHC Programmes, 1980; "New Partnership in Rural Development" by D. Paul Chowdhry.

Note: No information on item 10.

No. 2001
Seminar
West Bengal

Institute of Social Change and Social Welfare, Calcutta - 700 006

1. Started: In 1961

2. Coverage:

Rural and urban areas of Eastern India, particularly Calcutta in West Bengal.

3. Activities:

a. In 1971, it organized an inter-disciplinary, action-oriented seminar on "Calcutta", the aim of this project being to survey all the surveys and researches which had been completed on the city and had catalogued its needs; and to suggest a comparative programme of future research on the city's problems.

b. In 1973, the Institute organized a seminar on the problems of rural development in West Bengal to make a 'workshop level' study of the schemes of intensive development produced by the State Planning Board.

c. It has undertaken 2 studies on violence in Calcutta.

d. Regarding field action, the Institute works for rural development and urban welfare. Its emphasis is on slum development and creating a cleaner 'socio-psycho-hygienic' environment for Calcutta.

e. Has set up a programme for the integrated development of 'bustees in North and South Calcutta'.

f. Has established an effective dialogue with the erstwhile young Naxalites.

g. It has published a book called "City in Turmoil".

h. It held a study-cum-action seminar on "Education for Tomorrow".

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No. 2001
Seminar
West Bengal

4. Personnel and Training:

The Institute's Governing Body consists of 7 members - The President, Chairman, Vice-Chairman, Secretary and 3 Members. A Board of Research Consultants has been set up. The members of the Board comprise the senior research staff of the Institute each one taking responsibility for an area of study. The consultants are supported by full-time trained staff recruited on project basis and also by a hard core of trained social scientists employed by the Institute.

7. Sponsorship and Funds:

The Gandhi Peace Foundation (New Delhi) and the Gandhian Institute of Studies (Varanasi) are the joint sponsors of the Institute, which functions as an Inter-Agency body working in close collaboration with research institutes and universities of the zone. Besides the above 2 agencies, the Institute has also obtained the co-operation of the Patna and Calcutta Universities and the Ramakrishna Mission Institute at Narendrapur.

10. Outlook:

a. It plans to organise a number of study-cum-action seminars in each district of West Bengal.

b. Will intensify its work of urban and rural development.

c. In areas of research, it will organize 4 programmes of study.

d. Will organize a variety of training courses for social workers, researchers, youth workers, etc.

e. It will bring out publications, especially a 'peace series' for the promotion of social action for a non-violent society.

f. It will develop a cadre of its own staff for research.

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No. 2001
Seminar
West Bengal

11. Contact:

a. Rabindra Mukhopadhyay, Secretary, ISCSW,
12-D, Sankar Ghose Lane, Calcutta 700 006.

b. K. Roy Choudhury,
Chairman

12. Reference:

Booklet published by the Institute of Social Change and Social Welfare.

Note: No information on items 5,6,8 and 9.

No. 2002
Child Care
West Bengal

Integrated Children Development Services Programme, South-West Calcutta.

1. Started: In 1976.

2. Coverage:

Bustees in particular geographical areas.

3. Activities:

Setting up of 'Anganwadies' or children's centres in various small neighbourhoods (about 40 'Anganwadies' have been set up so far) to carry out different activities like nutrition, immunization, education and family planning counselling.

5. Supervision and Records:

Social Welfare Department of the State Government is administering the pilot scheme.

6. Community and Other Participation:

A state level and an area level co-ordination Committee assist the administration.

7. Sponsorship and Funds:

Programme has been formulated by the Indian Government with UNICEF expertize.

11. Contact:

Dr B. Bhattacharya, Programme Administrator (Health), CMDA (Calcutta Metropolitan Development Authority), and Mandip Chatterjee, Deputy Director, Planning , CMDA.

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No. 2002
Child Care
West Bengal

12. Reference:

K.C. Sivaramakrishnan; paper on "a review of the slum improvement programme in Calcutta with special reference to services for women and children" at a "Special Meeting on the Situation of Children in Asia with emphasis on Basic Services", April 1977, Organized by the United Nations Children's Fund.

Note: No information on items 4,8,9, and 10.

No. 2003
Health
West Bengal

The Kalikata Bustee Pragati Sangstha, Calcutta.

1. Started: In 1975

2. Coverage:

Bustee areas of Calcutta, where physical improvements have been secured or commenced.

3. Activities:

a. 26 Health Clinics were set up or supported.

b. Mahila Samities received assistance to develop craft training-cum-production centres.

c. Assistance (financial) to about 45 schools.

4. Personnel and Training:

A cadre of trained social workers operating in a multi-organizational framework like the Catholic Relief Services, Calcutta Youth Self-Employment Centre, Bengal Social Service League, etc.

6. Community and Other Participation:

a. Inter-action and collaboration with Europe-Calcutta Consortium (ECC), consisting initially of seven European agencies like West Germany's EZE, Holland's BOVAP, Bread for the World, United Kingdon's Christian Aid, etc.

b. Optimization of voluntary organizational efforts by Catholic Relief Services, CYSEC, BSSL, etc. which do significant work in nutrition, health, vocational training, self-employment, non-formal education.

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No. 2003
Health
West Bengal

7. Sponsorship and Funds:

Total outlay of about 5.5 million Dutch Marks (about Rs. 1.9 crores) was earmarked. Of this, 5.5 million were provided by the ECC and the rest was to be mobilized by the KBPS.

9. Problems

a. Absence of adequate, full-time programming, monitoring and co-ordinating staff within the KBPS itself.

b. Due to the variety of dynamic organizational bodies with their individual traditions, the KBPS has not been able to perform its assigned task of central planning and co-ordination.

c. Resolution takes time because of conflict of interests.

10. Outlook:

a. Financial assistance to primary schools in or near bustee areas.

b. Assistance for adult literary and other non-formal education programmes.

c. Employment promotion through credit service co-operative society, training-cum-production centres and vocational training courses.

d. Development of curative and preventive health services.

e. Assistance to programme administration at the central office.

f. Special training facilities.

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No. 2003
Health
West Bengal

11. Contact:

Dilip Roy, Programme Engineer, Bustee Improvement Wing, CMDA (Calcutta Metropolitan Development Authority).

12. Reference:

K.C. Sivaramakrishnan; paper on " a review of the slum improvement programme in Calcutta with special reference to services for women and children" at a special meeting on "the Situation of Children in Asia with emphasis on Basic Services", April 1977.

Note: No information on items 5 and 8.

No. 2004
Slum Improvement
West Bengal

Calcutta Metropolitan Development Authority (CMDA) - Environmental Improvement To Slums

1. Started: in 1970/71

2. Coverage:

(Initial) One million slum dwellers in the North, South-West, South-East parts of Calcutta city and in the industrial zones on the west and east banks of the river.

3. Activities:

a. Service latrines were converted to sanitary latrines with septic tanks.

b. 30,000 of the latter have been installed so far.

c. 12,000 odd water points and bathing platforms have been provided.

d. Over 700,000 square metres of pathways were paved.

e. 600,000 metres of sewer and underground drainage networks have been installed.

f. Provision of road and street lighting, dustbins and open spaces.

g. Schools, dispensaries were set up.

h. A small group of social workers recruited by the CMDA distributed nutritious bread and milk to children in the age group 0 - 6 by 1972, about 180 nutrition centres were set up in different bustees; an enlarged scheme now serves hot meals based on soya-bean preparations.

i. 680 Schools were renovated under another CMDA programme.

j. Expansion of health facilities.

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No. 2004
Slum Impvorement
West Bengal

k. Improvement in recreation facilities for children in the entire city.

l. Improving water supply and sanitation as a whole in the metropolitan city.

m. Major improvement in the transport system and special schemes for monitoring and reducing water and air pollution.

4. Personnel and Training:

a. A cluster comprising several bustee holdings with an average population of 5,000 - 6,000 people was taken as the basic operational unit. 4 or 5 such clusters were placed under a squad, which was the basic organizational unit functioning under an assistant engineer with supporting staff.

b. A group of squads was placed under a zone with an executive engineer in charge.

c. A chief engineer directed the programme.

6. Community and Other Participation:

a. Participation by bustee dwellers is significant.

b. Bustee Youth Clubs or recreation clubs interacted with the CMDA officials on the location of the various facilities and in securing the co-operation of the hutment dwellers in getting the work done.

c. A small group of social workers gave ample assistance.

d. Skilled physical labour was supplied by the urban poor, but on a payment basis.

e. Several voluntary organizations participated in the nutrition programme of the CMDA.

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No. 2004
Slum Improvement
West Bengal

7. Sponsorship and Funds:

a. The Government of India gave Rs.80 million as a grant. The CMDA was set up under a special statute to administer the development fund of the programme.

b. The Calcutta Urban Service Consortium (CUSCON) was organized as a forum of about 25 different voluntary organizations to co-ordinate their activities, especially in the bustee areas.

c. CUSCON began to receive funds from church agencies in Europe, especially W. Germany, and commenced a programme of starting/ supporting clinics, primary schools and mahila samities. Later CUSCON became a field organization on its own rather than a consortium of other organizations by providing funds, administering the schemes, joining with Government and other agencies and preparing annual budgets.

8. Evaluation:

a. A special exercise was undertaken to re-examine and establish the technical adequacy of the norms and standards formulated in the earlier Basic Development Plan. Officials of the CMDA, the Corporation of Calcutta, the CMPO and the engineering units carrying out surveys and field work participated. The Mayor of Calcutta and other non-official representatives were consulted.

b. Currently a metropolitan-wide survey is in progress, initiated by the CMDA and the State Government's health department and assisted by the Ford Foundation to identify present morbidity/ mortality characteristics.

c. The survey seeks to establish benchmarks to be reviewed periodically.

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No. 2004
Slum Improvement
West Bengal

9. Problems:

a. The maintenance of the improved facilities has been a major problem. The Corporation and other municipal bodies whose responsibility it is, lay the blame on lack of sources.

b. Often the environmental deficiencies are not confined to the bustees, but are present beyond their boundaries, so that the sewer and drainage networks are generally overloaded. In such cases, physical improvements have to cover the area as a whole, but cannot because of cost and technical limitations.

c. Removal of wastes (where cattle and people co-exist) poses a serious problem. Recently, the CMDA and the State Government initiated a scheme to resettle about 70,000 cattle in a number of small dairies at the metropolitan fringe.

d. The programme leaves the quality of the 'shalter' and the pattern of the slum untouched. The important limitation in this regard has been the land ownership pattern.

e. Cost of the dwelling unit forbids large scale re-development.

f. Lack of storage space and facilities for running the 'hot-meal' nutrition programme.

g. In the CMDA's health programme, inadequate logistic support has seriously limited the creation of new facilities and affected the running of existing ones;

11. Contact:

Dilip Roy, Programme Engineer in the Bustee Improvement Wing of the CMDA.

12. Reference:

Paper on " A review of the slum improvement programme in Calcutta with special reference to services for women and children" - K.C. Sivaramakrishnan.

Note: No information on items 5 and 10.

No. 2005
Education
West Bengal

Pipla Palli Samiti, Malda.

1. Started: In 1922

2. Coverage:

Remote rural areas of West Bengal.

3. Activities:

a. Rural, economic development and education department runs senior, junior and pre-basic (primary) schools; spinning, tailoring and weaving are taught in the senior basic schools; 3 schools in Pipla village have been started.

b. 4 Social education centres at Gangnadia, Pipla, Wari and Chokastan.

c. Runs a welfare centre for women, provided with sewing machines and recreational aids.

d. A library and reading room have been opened.

e. Has its own charitable homoeopathy dispensary, which treated 11,116 patients in a year.

f. Since 1964, the Samiti has been running a "school mother training centre" for distressed women - 1200 women have been trained so far, of whom 90% are now employed in different primary schools of West Bengal.

g. Distribution of milk powder among children.

h. It runs an animal husbandry and poultry farm.

i. It has a centre for cottage industries, where yarn is produced by residential workers and sold to other societies.

j. It produces jute fibre, provides for pottery, manufacture of building materials, carpentry, ghani operation training.

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No. 2005
Education
West Bengal

k. Runs a Radio Listening Centre.

l. 2 Tube-wells have been sunk in a Harijan village.

m. Arranges social gatherings with Harijan Participation.

n. A tribal welfare centre is being run at Wari.

o. Acts as mediator to solve cases of village disputes through arbitration.

p. Helps family planning work and runs an orphanage.

q. Gives relief and discretionary grants whenever required.

r. Has started a Consumer's Store (Palli Bhandar).

s. Helps farmers to improve methods and increase yields.

t. Helps them obtain irrigation facilities, better seeds, manure, etc. from the proper authorities.

u. Provides seasonal agricultural employment to an average of 50 persons.

v. In 15 years, has constructed permanent houses of mud wall, bamboo and tile frames under the self-help housing scheme.

4. Personnel and Training:

a. One trained "gram ekai sahayak" each has been provided for 6 villages. These "sahayaks" are doing preliminary survey works in the villages.

b. The Samiti has 12 Executive Committee Members, who are from various fields, such as jotdars, teachers, businessmen and cultivators.

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No. 2005
Education
West Bengal

7. Sponsorship and Funds:

The Samiti receives finances for its projects from its own membership fees; Government grants from various departments such as Block Development Offices, Social Welfare Board, Department of Social Education, Department of Physical Education, District Boards, Gandhi Smarak Nidhi; and also from its own properties. Some of its projects bring in some returns.

10. Outlook:

a. The Samiti plans to establish a dairy of its own because of high local demand for milk.

b. Efforts are being made to initiate artificial insemination to improve cattle breed.

c. Has proposed a scheme to the West Bengal Khadi and Village Industries Board to start a Leather Tanning and Bone Crushing Centre.

d. Plans to construct a residence for lady workers.

11. Contact:

Shri Subodh K. Misra, Secretary, Pipla Palli Samiti, P.O. Pipla Dist., Malda (West Bengal).

12. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda.

Note: No information on item 5,6, 8 and 9.

No.2006
Education
West Bengal

Ramakrishna Mission Ashrama (RMA), P.O. Narendrapur, N. Calcutta.

1. Started: In 1943;

2. Coverage:

People of rural and urban areas, mostly in the districts of Midnapore, Bankura and 24-Parganas of West Bengal; and those who are socially or otherwise handicapped.

3. Activities:

a. General Education.

b. Technical and vocational education for which it runs a residential school.

c. Education for the physically handicapped; for this it runs a Blind Boys' Academy.

d. Undertakes many programmes for scheduled castes and tribes.

e. Youth leadership training, mass education and rural uplift.

f. Child welfare work- milk and other food are distributed through its 86 village Welfare centres to about 21,000 children daily - they are taught elementary hygiene.

g. Free medical help to deserving persons.

h. Social service camps are organised, where students repair roads, cut down jungles and dig compost pits.

i. Relief work is undertaken during times of calamity.

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No. 2006
Education
West Bengal

4. Personnel and Training:

Village workers are trained in leadership and farming by experts. The Managing Committee consists of 14 members.

5. Supervision and Records:

Particular activities are looked after by special units of the Ashrama, such as the Gram Sevak Training Centre; Institute of Social Education and Recreation and Rural Development Department.

7. Sponsorship and Funds:

Grants are given mainly by the Central and State Governments; and it also receives public donations.

11. Contact:

Swami Askatananda, Secretary, Ramakrishna Mission Ashrama, P.O. Narendrapur, Dist. 24-Parganas (West Bengal).

12. Reference:

"Reports on Voluntary Agencies in India" - Prof. M.B. Achwal, Director, "HEART", Baroda

Note: No information on items 6, 8, 9 and 10.

No. 2007
Education
West Bengal

Vivekananda Social Welfare Centre (VSWC), Calcutta.

1. Started: In 1952.

2. Coverage:

Kalabagan and Rambagan Bustees in North Calcutta.

3. Activities:

a. Training and income supplementation programmes.

b. It runs 2 schools, the Vivekananda Junior Basic School (which was started as a primary school and later converted into a free junior basic school), and the Vivekananda Nursery School for children of the 3 to 6 age-group: children of both the schools are given free tuition and books.

c. It started a 3-year course in tailoring and weaving for Harijan women, who are given a stipend of Rs.15/- per month during the course. After completion, they are given work on a sub-contract basis.

d. Adult Literacy Programme for women.

e. Opened a training-cum-production centre where free training in cane and bamboo crafts is being given to youngsters of the slum areas. This Centre arranges for marketing of the finished products. The Centre also runs a 3-year training course in painting.

f. Under its nutrition programme, the VSWC daily distributes bread to 2,200 children through 13 centres to Kalabagan and Rambagan bustees. Two milk centres supply milk to about 320 children in Rambagan.

g. A medical unit was opened in 1955. Free medicines and sometimes free diet are supplied to patients.

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No. 2007
Education
West Bengal

4.

h. Evening coaching classes for local students.

4. Personnel and Training:

In the Managing of the Ashram (a parent organization of the VSWC), there are 15 members, including a nominee of the Indian Government. In the Centre itself, there are 48 members.

7. Sponsorship and Funds:

The VSWC receives yearly grants from the Central and State Governments and public donations.

11. Contact:

Shri D.P. Sil, Superintendent, Vivekananda Social Welfare Centre, 17, Nanda Mullick Lane and 9/1 Ramesh Dutta Street, Calcutta 700 006 (East Bengal).

12. Reference:

"Reports on Voluntary Agencies in India" -
Prof. M.B. Achwal, Director, "HEART", Baroda.

Note: No information on items 5,6,8,9 and 10.

No. 2008
Nutrition
West Bengal

Child In Need Institute (CINI), Calcutta.

1. Started: In December 1975.

2. Coverage:

About 4,000 children under 6, belonging to the lowest socio-economic group living in and around Calcutta.

3. Activities:

a. Distribution of CINI-NUTRI-MIX, a locally made nutritious food supplement, by village mothers; also blended foods from Catholic Relief Services.

b. A children's hospital to provide emergency and routine medical care up to a maximum of 25 children is under construction.

c. Mothers are admitted here with their children in order to train them in health care and education, prevent further illnesses and hygienic child rearing practices.

d. A training centre to provide selected village mothers training in paediatrics, nutrition, environmental health and other aspects of community development is complete. A 6-month course here trains paramedical workers - "Mother and child health workers", who render integrated package of services at the 'grass roots' level.

e. Mobile and static "under fives clinics" in different locations, providing basic health care (e.g. immunization) to children on food supplement.

f. Integrated Rural Welfare Project has been started as a subsidiary of CINI at Raidighi. This project started dehydrating prawns and marketing them.

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No. 2008
Nutrition
West Bengal

4. Personnel and Training:

A Chairman, Director, Financial Controller and four members implement the various activities of the Institute.

5. Supervision and Records:

a. Making of CINI-NUTRI-MIX by the lower socio-economic group mothers is supervised by trained mother and child health workers.

b. Trained MCH Workers supervise growth and development of the under-sixes covered in this programme. They also diagnose, treat, and give health education under a doctor's supervision.

c. A mobile nutrition education team of 2 trained MCH workers goes round regularly to recapitulate activities.

6. Community and Other Participation:

a. The local community helps in selecting the beneficiaries by providing rent free, food distribution ./clinic space. A token contribution is charged for all services rendered. To provide these services, CINI receives financial assistance from various agencies to build an administrative office, training centre, food godowns, garages and a children's hospital.

b. Many voluntary and Government Organizations meet CINI representatives and share experiences through discussions.

7. Sponsorship and Funds:

CINI is working in close collaboration with the Socio-Economic Development Project (SEDP). The Institute receives funds from the Department of Health and Family Welfare, Government of West Bengal, and organizations like the Catholic Services, USCC, Calcutta; Seva Kendra, Calcutta; Lutheran World Federation, Sweden; Brot Fur Die Welt, W.Germany; and the Central Inland Fisheries Department, Government of India.

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No. 2008
Nutrition
West Bengal

8. Evaluation:

The various methodologies used in the programme is evaluated periodically. Morbidity, mortality and nutrition surveys are conducted in addition to checking the weight for age health cards.

9. Problems:

a. Initial difficulties regarding marketing of dehydrated prawns.

b. To combat illiteracy, a major problem in many villages, it is proposed to expand functional literacy projects for mothers.

10. Outlook:

It is proposed to make CINI function as a training institute for:

a. MCH workers:

b. Administrators for various relief programmes for mothers and children and disaster relief organizations; and

c. Doctors, nutritionists and public health nurses.

11. Concact:

a. Mr James DeHarpporte
Director
Catholic Relief Services - USCC
Calcutta Zone
50, Circus Avenue
Calcutta.

b. Dr S.N. Chaudhury, Director, CINI,
197/722 Diamond Harbour Road, Thakurpukur,
Calcutta - 700 063.

12. Reference:

Annual Report, 1976/77 of the Child In Need Institute.

No. 2009
Health
West Bengal

Comprehensive Health Project, Rangabelia

1. Started: In 1977.

2. Coverage:

9500 population in 5 villages of Rangabelia Island initially; later, 37 villages scattered over 8 islands.

3. Activities:

a. Health care programme with emphasis on prevention of diseases and health education.

b. Improvement of housing conditions.

c. Ensuring supply of safe drinking water to every family in the project area.

d. Mass immunization; evolving sanitary latrine systems.

e. Providing loans and agro-service assistance for back-yard poultry and kitchen gardens to ensure a nutritious diet.

f. Popularising family planning methods.

g. Providing curative treatment of simple diseases by trained VHWs at the village level.

h. Comprehensive development project (started 1975) is linked to the Health Project; and includes productive activities like agriculture; pisciculture; women's programmes through Mahila Industrial Cooperative Society; Non-formal Education and Functional Literacy etc.

4. Personnel and Training:

a. Local girls and boys are trained, so that ultimately the project may run with locally available technical skill.

b. For the Health Care programme, the first batch of 24 boys and girls was trained at Rangabelia by a qualified doctor and his qualified nurse wife. After they left at the end of the two years, four more training programmes were

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organized with the help of Calcutta Hospital specialists.

c. The Health Project has the following personnel: Director, (local medical practitioner); Medical Officer (local young man who is whole time residential Medical Officer); 2 ANMs deputed by the Government Health Department; 5 locally trained nurses attached to the Central Medical Team; 6 local young men trained in pathology, pharmacy and accountancy; 62 trained VHWs working in different villages.

5. Supervision and Records:

Follow-up action after the training programmes is supervised by the Director of the Health Project and the M.O. They meet the trained VHWs once a week and give necessary instructions.

6. Community and Other Participation:

a. Health needs and priorities of a particular village are identified by the villagers themselves.

b. Workers are selected by villagers at meetings.

c. The Health Department of the Government has been closely associated with the effort from the beginning.

d. Villagers are involved at every stage.

7. Sponsorship and Funds:

a. Initial finance for construction of buildings, equipment and other accessories has been provided by the parent organization - Tagore Society for Rural Development.

b. Recurring expenditure is met by the beneficiaries themselves; the Government Health Department and from donations given by individuals and organizations.

c. Government also provides other assistance, - such as vaccines, injections, bleaching powder, family planning materials, etc.

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No. 2009
Health
West Bengal

8. Evaluation:

Decisions in all matters are taken and evaluations made at village meetings, and if programmes are not implemented satisfactorily by the workers concerned, the next meeting calls for an explanation and if necessary, action is taken against the "erring" worker.

9. Problems:

Poor motivation by the motivator - The greatest hindrance to participation by the people is the lack of proper motivation by those who are at the helm of affairs.

11. Contact:

Tushar Kanjilal,
Headmaster,
Rangabelia High School
Village and P.O. Rangabelia (via Gosaba),
24 Parganas, West Bengal.

12. Reference:

Paper presented at the National Conference on Evaluation of PHC Programmes, 1980.

Note: No information on item 10.

No. 2501
Health
Delhi

Okhla Neighbourhood Comprehensive Health and Welfare Pilot Project
Holy Family Hospital, Okhla.

1. Started: In 1969; the Comprehensive Welfare Project was inaugurated as an integrated programme of Health, Welfare and Education in 1972.

2. Coverage:

12 villages near South Delhi with an urban-rural population of about 20,000 people.

3. Activities:

a. Health Education, MCH;

b. Family Planning;

c. Applied Nutrition;

d. Medical aid; school health;

e. Communicable disease assistance control - to be achieved through immunization;

f. Basic hygiene education; social family welfare services;

g. Rural health training;

4. Personnel and Training:

Part-time doctor, volunteer doctors, public health nurse, four lady health visitors, nutritionist, social worker, part-time lab. technician, Municipal family planning worker, village motivator-cum-auxiliary, driver and part-time/full-time volunteers. Six VHWs are serving local people at the new site at Trilokpuri.

5. Supervision and Records:

At the onset of the programme, a house-to-house survey was made. For each family, a family folder as a permanent record was kept. Each family got an identity card. Regular home visits are made for serious patients who need domiciliary care.

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No. 2501
Health
Delhi

6. Community and Other Participation:

The participating agencies are:

a. Holy Family Hospital.

b. Jamia Milia School of Social Work;

c. Dr. Zakir Hussain Memorial Welfare Society; and

d. The Don Boscoe Technical Training School.

e. In some villages, and in Okhla, The Family Planning Centre was given by a village resident as a base for the clinics; in Masigarh, another centre(donated by the Parish) has been set up for clinics to serve the other villages;

f. Jamia Milia Islamia has also contributed to the Mukhya Sevika Training Project.

g. Village women volunteers help in the sewing and cooking projects.

7. Sponsorship and Funds:

a. ANP is sponsored by three agencies: (i) UNICEF; (ii) GOI; (iii) Catholic Relief Services;

b. The Delhi Administration, through a Public Health Grant, is assisting with education and some salaries;

c. The Communicable Disease Assistance Control is aided by the Municipal Corporation, which also cooperates with family planning workers and sanitary inspectors for the area.

d. Donor agencies are: Zentralstelle; OXFAM; CRS; Caritas; UNICEF; AVA, New Delhi; T.B. Centre, Municipal Corporation; Holy Family Hospital Ladies Auxiliary; Delhi Administration; Central Social Welfare Board.

8. Evaluation:

a. In 1972, public health experts and doctors doing similar health work elsewhere made a constructive evaluation of the programme.

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No. 2501
Health
Delhi

b. Periodical work and personal development evaluation is carried out.
Most of the evaluation is done through statistical indicators.

c. In December 1974, three years after the Project was started, the scheduled evaluation was undertaken by K.M. Pelzer, Head, Analysis Department of the IGSSS, New Delhi.

9. Problems:

a. In 1975, villagers were shifted for resettlement, making unemployment as well as health, a problem.

b. Effective participation of the people with a view to "root" the work in them has not been realized because of:

(i) The migratory nature of the population;

(ii) Rising costs of food and medicine;

(iii) Social-economic stagnation; and

(Iv) very little sense of any community bonds.

c. No officially recognized leadership base (Panchayat/ Pradhan) for discussing common problems.

10. Outlook:

a. Training of more Village Level Workers.

b. Give intensive health education to the whole village, so that all become aware of health.

c. Train the VLWs to treat minor ailments at home.

d. Improve the sanitary conditions of the poeple.

e. Continue minimal curative care and involve the community people more.

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No. 2501
Health
Delhi

f. Begin work in other villages.

g. Start a course for MPWs.

11. Contact:

Dr. Shobha Misra, Okhla Neighbourhood Comprehensive Health and Welfare Pilot Project, Holy Family Hospital, Jamia Nagar, New Delhi 110 025.

12. Reference:

VHAI; paper presented at the National Conference on Evaluation of PHC Programmes, 1980.

No. 2502
Child Care
Delhi/Maharashtra

Mobile Creches for Working Mothers' Children,
5-B, Telegraph Lane, New Delhi- 110 001

1. Started: In 1969.

2. Coverage:

Delhi: In 1975, the number of centres was 27,12 of which were new, 2700 children were covered. Also, students literacy centres with 275 men and 75 female students were run. Bombay has 8 centres in operation. Approximately 850 children were covered.

3. Activities:

The objective is to provide facilities for construction and other women labour to leave their children in an organized creche while at work.

a. Creches for children under 3 years.

b. Pre-school education for 3 - 6 years olds (815 children in Delhi).

c. Primary education to prepare the disadvantaged children to enter corporation schools (175 children in Delhi).

d. Arts and crafts for all children, excursions, camps, etc.

e. Vocational Training for older children.

f. Health - regular visits by doctor; immunization; maintenance of health records; (8138 children treated in Delhi; plus 2023 adults).

g. Supplementary Nutrition including special diets for under threes,snacks for older children.

h. Adult Literacy.

i. Community Work - mothers' meetings, including demonstrations.

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No. 2502
Child Care
Delhi/Maharashtra

j. Training for own as well as other institutions' staff.

k. Lok-doot, the cultural troupe of Mobile Creches, was launched in 1977 to motivate and educate people in various aspects of the literacy programmes. Lok-doot produces skits, small plays and children's plays based on stories from "Panch Tantra" and "Hitopadesh".

4. Personnel and Training:

a. Creche workers and teachers - 105; continuous in-service training sessions - 1/2 day each month.

b. Other staff: school supervisors - 8; art teachers - 4; doctors - 4; nutritionists - 2; education planner - 1; trained teachers - 2; research and evaluation - 6; administration - 6; carpenters - 3; adult literacy co-ordinator - 1; adult literacy supervisors - 3; adult literacy instructors - 21 (total 170).

5. Supervision and Records:

Within the organization itself there is a scheme for educational supervisors who have at least a B.Ed. degree and some training. They know modern techniques, can solve teachers' problems that arise in checking the syllabus and keep a record of the children's progress. They also have to organize and supervise training programmes. After 3 or 4 years of service and experience, when the teacher attains abilities of community involvement, decision making and an ability to organize, she herself is promoted to supervisor.

A teacher-in-charge observes the new teacher recruit for an assessment of her qualities. If the former responds favourably, she is given a rigorous training programme.

The supervisory cadre, therefore, is drawn from the existing staff so that supervision is backed by a thorough knowledge and understanding of the situation.

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No. 2502
Child Care
Delhi/Maharashtra

6. Community and other Participation:

a. Right from the beginning Mobile Creches had whole-hearted support from the children on construction sites as well as slums. Parental acceptance also came with time.

b. At first, a few families were identified as contact points and asked to do small chores for the centre.

c. In some slums mothers give small donations on certain festivals which are accepted gladly.

d. When a new centre is opened, mothers' meetings are organized and nursery activities explained to involve total participation from the mothers, which sometimes comes in the form of providing charcoal stoves for the centres in winter. Cooking demonstrations helped in further participation by mothers. Acceptance by the creche workers of the simple Indian tradition of hospitality, resulted in community involvement.

e. In the early years, contractors also supported Mobile Creches with accommodation, water facilities and monthly contributions.

7. Sponsorship and Funds:

The voluntary organization is supported by a law which provides for creches and other facilities for children of construction labour with part of the cost being met by the building contractors, and part by government. In addition, the organization gets donations and raised funds.

8. Evaluation:

Workshops are organized as sessions for planning, evaluation and as periods of introspection.

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No. 2502
Child Care
Delhi/Maharashtra

9. Problems:

a. Opposition from a few parents who were reluctant to send their children to the Municipal elementary schools for which the Mobile Creches prepare them. Even now, parents do not want to send them, especially their girls.

b. School drop-outs. About 80% who join elementary schools drop out for various reasons, the most important being poverty.

c. A child from a background of poverty, with illiterate parents and bare atmosphere at home lags behind in his studies. Mobile Creches tackles this problem by continuing special coaching in the elementary schools. Annual summer schools are organized to help the child keep up with the rest of the class and educational tours are included in the curriculum.

d. The Elementary school teacher's prejudice which hampers the child's progress - this prejudice arises from the pre-conceived notion that a slum child is dirty, uses bad language and will steal things.

e. The attitudes of the contractors at the work sites. To many, the children were always an outside entity. The stamp of "these children" was too glaring to ignore. Contractors invariably gave accommodation without doors, windows, floors.

f. Water facility was very often not given - this was made a big issue till the contractors were convinced that this facility ought to be provided.

g. The temptation for the teacher to neglect the poorer child who may not have his mother around to bring him cleaned to the centre.

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No. 2502
Child Care
Delhi/Maharashtra

h. Wrong attitudes of the unimaginative professional. The moment one has higher degrees in social work and relevant subjects, one becomes completely remote from field activities.

i. Failure to bring a healthy environment in the labour camp as well as in the slums. Sanitation is still a problem.

j. The economic level of each family could not be improved.

k. In training workers, there are plenty of frustrations - there is a lack of good, solid workers with a combination of efficiency and commitment.

10. Outlook:

Mobile Creches has great scope for expansion because of the increasing construction work going on. Workers' participation is sought to be encouraged by identifying and then providing their needs and requirements.

11. Contact:

Ms Devika Singh, Ms Mina Swaminathan.

12. Reference:

Annual Report for 1975 of Mobile Creche; WIO UNICEF Note.

No. 2503
Education
Delhi

Low Income Family Emanicipation (LIFE) Society, New Delhi

1. Started: In 1971

2. Coverage:

Slum dwellers of Laxmibai Nagar.

3. Activities:

a. School for poor children was started (at least 3 students from this school stood first in their classes in Government schools to which they were admitted later). This school was multi-purpose and was called the Neighbourhood Community Training Centre - NCTC.

b. Supplementary income scheme were started for women (knitting, sewing, making plastic-wire shopping bags).

c. LIFE maintained an open-air library to distribute Hindi books and newspapers.

d. Educational picnics, film shows, family planning guidance, adult literacy, nutritious food-cooking, medical treatment were arranged. 2 Voluntary doctors visited the slums once a week and looked after the health of the people; 2 nurses demonstrated hygienic house-keeping, child-care and nutritious cooking.

e. The social awareness created by LIFE motivated the beneficiaries themselves to approach NDMC for construction of drainage, installation of hand-pumps for water, building lavatories and pave muddy paths.

f. The Mohammadpur Labour Camp, Sarojini Nagar slums and mechanics at Ring Road, R.K. Puram, were also taken under the Society's care.

g. Better housing was organized with better ventilation and hygienic conditions; The Society submitted a cheap housing scheme to the Government (Later, D.D,A.'s (Delhi Development Authority) well-planned housing colonies resettled the slum-dwellers in N. Delhi suburbs.)

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No. 2503
Education
Delhi

h. NCTC children were awarded scholarships of Rs. 100/- each.

i. "Health Services" by Dr D.H. Shete looks after the health of about 55,000 residents of Dakshinpuri, where LIFE has acquired 25 sq. yds. of land.

j. Life Insurance Policies for 2 children for their eudcation/marriage expenses were taken by a benefactor.

k. Help is given to the All-India Harijan Welfare Association for fulfilment of its objectives.

4. Personnel and Training:

A small group of dedicated individuals are running this Society. The Secretary is a permanent executive of the sub-committees as well. The teachers at the various centres are ex-officio members. An Advisory Committee under the Chairmanship of Mr Justice Chandrachud, visits the Centre periodically.

6. Community and Other Participation:

Eminent people like Mr Dharma Vira, the Most Rev. Dr. A.Fernandes, Archbishop of Delhi, Mr Justice Chandrachud of the Supreme Court, Mr S.Singhania, industrialist, are closely associated with the Society. The All-India Harijan Welfare Association works along with LIFE to help the people of the area.

7. Sponsorship and Funds:

LIFE finds its meagre finances through its quarterly journal called UPLIFT. Some funds come from advertisers, subscribers to the journal and donors.

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No. 2503
Education
Delhi

9. Problems:

a. LIFE finds it difficult to serve the 55,000 residents of Dakshinpuri with the small plot of land given to it. Crafts like candle and chalk-making require more space.

b. LIFE's chairman for Health Services too needs additional space to store medicines and render other allied services.

c. The Society also suffers from lack of sufficient finance. Government and voluntary financial agencies have not come forward to help so far.

10. Outlook:

a. To establish a home for the above 60s among the aged poor.

b. Trying to reach slums in other metropolitan cities like Bombay and Calcutta.

11. Contact:

T.J. Abraham, Founder President, LIFE Society.

12. Reference:

"UPLIFT", a fortnightly published on behalf of LIFE society, B-3/40, Safdarjang Enclave, New Delhi 110 016.

Note: No information on items 5 and 8.

No. 2504
Community Development
Delhi.

Bharatiya Grameen Mahila Sangh (BGMS)

1. Started: In 1955.

2. Coverage:

This is an all-India organization for the overall welfare and development of rural women and children all over India.

3. Activities:

a. Maternity and child care.

b. Family planning.

c. Craft-cum-production centre.

d. Social education.

e. Balsevika training programme.

f. Adult education.

b. Home for the aged and for the blind.

h. Mobile libraries.

i. Kitchen gardens and poultry farming.

j. Balwadis.

k. Farm women training programme.

l. Nutrition demonstration and education.

m. Exchange of farmers' programmes.

o. Socio-economic programmes.

p. Community centres, seminars and group programmes.

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No. 2504
Community Development
Delhi.

7. Sponsorship and Funds:

The Sangh has its affiliation with the international organization, "the Associated Country Women of the World" which has consultative status with UNESCO, UNICEF and FAO. Funds are made available through Government grants, membership contributions, donations and fund-raising programmes.

IO. Outlook:

a. To establish new grameen samitis.

b. To undertake intensive work among rural women.

c. To assist in all the constructive work undertaken in the 5-year plans.

d. To improve the working conditions of rural house-wives.

e. To co-operate with other national organizations in tackling rural problems about agriculture, cottage and small-scale industries, rural health, housing and home science extension.

f. To undertake pilot projects to encourage rural women to become training-minded.

11. Contact:

Ms. Wahabuddin Ahmed,
B.G.M.S.
9/104, Jamnagar Hutments,
Man Singh Road, New Delhi 11o 011.

12. Reference:

"Community Level Approaches to Health and Nutrition" (As possible ways to reach populations which are difficult to cover by centrally designed and operated government programmes) - by Dr Rajammal P. Devadas, Director, Head and Professor of Nutrition, Sri Avinashilingam Home Science College for Women, Coimbatore.

No. 2505
Community Development
New Delhi

Himalaya Seva Sangh, New Delhi

1. Started: In 1970

2. Coverage:

Socio-economic development of the entire Himalayan region.

3. Activities:

a. Promotion of community action for social and economic development in the Himalayan regions.

b. Instils self-reliance among the people in the area and tries to improve their living conditions.

c. Promotional activities in the sphere of Khadi and Village Industries, forestry, agriculture and animal husbandry.

d. Tries to create mass awareness of the problems of the region through publications, seminars, camps, conference, etc.

4. Personnel and Training:

The Sangh has been divided into 3 sections:

a. Central office - to coordinate activities of the social workers in the various sub-regions of the Himalayas.

b. West Himalaya office consisting of states west of Nepal, viz. Uttarkhand areas of U.P., Himachal Pradesh and Jammu and Kashmir.

c. East Himalaya office consisting of areas east of Nepal, viz. hill districts of West Bengal, Assam, Arunachal Pradesh, Nagaland, Meghalaya, etc. Both these regions have their own offices and advisory committees to plan their own programmes.

d. Local committees have been formed for Meghalaya and Manipur.

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No. 2505
Community Development
New Delhi

7. Sponsorship and Funds:

The annual interest from an endowment of Rs.12.50 lakhs provided by the Central Gandhi Smarak Nidhi.

11. Contact:

Chairman
Himalaya Seva Sangh
Rajghat, New Delhi 110 002

12. Reference:

Brochure published by the Sangh.

Note: No information on items 5,6,8,9 and 10.

GLOSSARY

AISS	-	All India Seva Samiti, (Allahabad).
ANM	-	Auxiliary Nurse Midwife.
A.P.	-	Andhra Pradesh.
C.C.	-	Child Care.
C.D.	-	Community Development.
CMDA	-	Calcutta Metropolitan Development Authority.
CRDS	-	Centre for Regional Development Studies (Surat).
CRS	-	Catholic Relief Services.
DDA	-	Delhi Development Authority.
DPAP	-	Drought Prone Area Programme.
DSW	-	Department of Social Welfare.
EMTSF	-	Efficient Management Technique for Small Farm.
GBSK	-	Gram Bal Shiksha Kendra (Kosbad Hill).
GOI	-	Government of India.
ICSSR	-	Indian Council of Social Science Research.
IGSSS	-	Indo-German Social Service Society.
IRD	-	Integrated Rural Development.
ISCSW	-	Institute of Social Change and Social Welfare, Calcutta.
ISI	-	Indian Social Institute, Bangalore.
KBPS	-	The Kalikata Bustee Pragati Sangstha (Calcutta).
KSSS	-	Kottar Social Service Society(Nagercoil).
KVIC	-	Khadi and Village Industries Commission.
LHV	-	Lady Health Volunteer.
LIFE	-	Low Income Family Emancipation (Society).
MCH	-	Mother Child Health.
MHW	-	Multipurpose Health Worker.

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MMC	-	Mallur Milk Cooperatives.
NCERT	-	National Council for Educational Research and Training.
NCTC	-	Neighbourhood Community Training Centre.
P and S Medicine		Preventive and Social Medicine.
PHC	-	Primary Health Centre.
PTSWs	-	Part-time Social Workers.
SBI	-	State Bank of India.
SC	-	Sub-Centre.
SCERT	-	State Council for Educational Research and Training.
SEDP	-	Socio-Economic Development Project.
TRYSEM	-	National Scheme of "Training Rural Youth for Self-Employment".
VHS	-	Voluntary Health Services.
VHW	-	Village Health Worker.
VLWs	-	Village Level Workers.
VRO	-	Village Reconstruction Organization.
VSWC	-	Vivekananda Social Welfare Centre, (Calcutta).